A Guide for the Control of Erroneous Medicaid Expenditures

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1.0 INTRODUCTION

1.1 Background

The purpose of this document is to present a guide which can be used by state Medicaid agencies to improve controls for preventing erroneous payments. This guide was developed in the course of a contract with Control Analysis Corporation of Palo Alto, California. It incorporates findings, both positive and negative, resulting from assessments performed in the contract of the controls on erroneous payments in eight states. The hope is that all states can benefit to some degree from the observed strengths and weaknesses of the eight states examined.[1]

For the purposes of this guide, erroneous payments have been defined as any payments made contrary to clear-cut regulations or policy, Federal or State. As such, this definition excludes payments for services which may be considered overutilization where the latter is defined in terms of medical judgement, even while such payments may be contrary to policy in a general sense. While this area is viewed as being of great importance, it was excluded from the scope of this investigation. However, where certain utilization controls, such as prior authorization, have been established in the regulations, payments contrary to those controls are indeed defined as erroneous payments, e.g., payment for a claim lacking prior authorization where prior authorization is required. For convenience purposes, erroneous payments are organized into the following major categories: ineligible recipient; ineligible provider; duplicate payment (exact and near); above allowed "reasonable" charges; other sources of payment available (other insurance, Medicare, accident liability, patient spenddown, and co-payment);

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[1]The eight states are Virginia, Nebraska, Connecticut, North Dakota, Kansas, Oregon, Oklahoma, and Georgia.

incorrect and/or incomplete claim; other payments not allowed by regulation or policy (e.g., cosmetic surgery, incidental surgical procedures, post-operative visits billed by a surgeon, etc.).

The guide consists basically of three components. First, a checklist is provided which identifies possible erroneous payment claim situations common to most states. A state may use this checklist to help assess the completeness of its claims processing controls for erroneous payments. Second, a summary is presented of the control weakness observed during the course of the eight state assessments, and such a summary should be useful to a state in determining whether it may have similar problems. Finally, a variety of control procedures are presented which a state may adopt for specific areas of erroneous payments, many of these procedures having been observed during the state assessments.

Note, it is not intended that this guide define a comprehensive system specification to be adopted in its entirety in every state. It is rather a collection of control ideas, some or all of which may be of use to any given state. The guide should be helpful to any state attempting to develop specifications for a new Medicaid Management Information System (MMIS). Alternatively, it can be of use in aiding states to improve specific areas of their existing controls where there are weaknesses. The various control concepts in the guide have therefore been presented as independently of each other as possible, and both manual and computer methods have been included, so that the suggestions will be of use to a wide variety of states.

It should be noted at the outset that two crucial elements of any system for controlling erroneous payments are:

1. a quality assurance function (including techniques such as paid claims sampling) to monitor the level of erroneous payments made; and
2. an evaluation and planning function to determine, on a continuing basis, the cost-effectiveness of increased or reduced erroneous payments controls in particular areas.

Only in this way can a State adequately keep abreast of its changing needs and thus make informed decisions regarding controls such as those presented in this guide. Thus, a particular control may be cost-effective for one state but not for another due to differences in patterns of medical care and differences in recipient populations. Furthermore, the cost-effectiveness of controls is a dynamic issue, where a control which is not needed at one point in time (or is too costly considering the benefits it brings) may become necessary at a later point in time. A small area of erroneous payments may become a large one, as regulations change, as providers learn about the system, or as the deterrent effect of the controls changes over time. This only serves to emphasize the need for some routine set of procedures which enable a state to periodically assess the need for new controls as well as consider the possibility of dropping existing controls. These points are discussed in greater detail in subsequent sections of this report.

1.2 Organization and Use of this Guide

Since erroneous payments are dynamic and differ from state to state, the first step in using this guide must be to identify those areas in a state's system where controls are lacking or incomplete. The Appendix provides a basic list of potential erroneous payment situations which are generally applicable to all states. These situations may be considered as a "test

matrix" which can be used to determine the adequacy of state controls. That is, if the state had a facility for testing system response to fictitious claims, the list of claim situations in the Appendix could be used to generate a comprehensive set of test claims which are known to be erroneous and which thus provide a good test of the state's controls. While most states do not have such a facility for test claims, such a list of erroneous situations can nevertheless be used as a guide to determine the presence or absence of controls for detecting each such situation. That is, one can ask, "what would occur if such a claim were submitted". The list of erroneous claim situations has been developed for the purpose of such an approach.

The list in the Appendix should be custom-tailored to the specific policy and regulations of the state. In some cases, the list indicates that particular erroneous claim situations are conditional on state regulations, and in these cases, the State Plan and provider instructions must be examined to determine whether the claim situation must be changed to fit the particular state situation. Additionally, the State Plan and provider instructions must be examined to determine whether additional claim situations should be added to reflect specific state policy or regulations. For example, if the provider instructions state that "chiropractic visits over two per month must be prior authorized", then an appropriate erroneous claim situation is "Claim for third or greater chiropractic visit in a month, without prior authorization".

In Section 2 of this guide, there is a discussion of the control problems observed during the course of the assessments of erroneous payments in eight states. This discussion should be of additional use for determining control weaknesses, as a state may recognize problems in its own system similar to those noted.

Once existing controls have been evaluated using the Appendix and Section 2, the next step is to determine how improved controls can be implemented where deemed appropriate. In this regard, it should be noted that merely identifying a potential erroneous payment situation is often all that is needed to determine how such a situation can be controlled; that is, the appropriate method of control is often straightforward and obvious once the need for control has been identified. Thus, in a sense, the Appendix and Section 2 serve also as a guide for controlling erroneous payments in addition to being a guide for identifying erroneous payments. Furthermore, in the Appendix, comments are often provided which point to possible methods of control where such methods are not self evident.

Additional information on methods of control is presented in Section 5. In that section, we present a number of techniques which have been selected based on their applicability to a variety of states and based on certain unique or non-obvious features. That is, the reader of the Appendix would not naturally arrive at such techniques as the obvious method of control. In many cases, the techniques have been observed in operation in a state, and state references have been cited where appropriate. In other cases, the techniques are the result of accumulated experience with erroneous payments in the eight states.

Once control weaknesses have been identified and possible system improvements noted, a state must make its own determination whether it is cost-effective to implement specific improvements. For this purpose, if the state currently engages in quality assurance and system evaluation and planning activities, this task will complement those activities. (For more discussion of quality assurance and system evaluation and planning, the reader is referred to Sections 3 and 4.)

In the analysis of whether additional controls are desired, particular attention should be paid to grouping erroneous payment situations, as this can significantly affect the cost-effectiveness of a solution. For example, considering the control of history-related situations (see Sections 2.3 and 5.1), one particular history-related situation by itself may not justify extensive changes. If several situations are present, all requiring the same solution, the changes may well be justified by the total cost-savings possible. On the other hand, a state may already have effective controls in most history-related areas, in which case an extensive change to the system may not be worthwhile. It is in this way that considerable differences may arise between one state and another, in the way that particular problems are approached.

In summary, this guide is in fact no more than a guide. It can help identify areas where controls on erroneous payments are lacking or weak. It can also help identify possible improved methods of control. However, it cannot substitute for the state's analysis of its own situation as a means for making informed decisions on what system changes are desired.

1.3 Significant Erroneous Payment Categories

During the eight state assessments, one important activity was to obtain samples of claims which were denied, reduced, corrected or returned to providers, in order to measure the impact of each state's controls on the detection of erroneous payments. It is useful to summarize the results of those samples in order to note the erroneous payment categories impacted most significantly by states' controls. By noting the significant categories, the reader can more easily maintain perspective when considering the lengthy and detailed list of erroneous payments in the Appendix as well as the discussions in the following sections.

Table 1 summarizes those erroneous payment categories, in the eight states reviewed, which were found to be significant in terms of the number and dollar value of erroneous claims detected. Erroneous payment categories have been included in this table if the number of errors detected per 100 claim line items exceeded 0.1 in at least one state, or if the dollar value of errors detected per $100 in paid claims exceeded $.10 in at least one state. If these quantities exceeded 1.0 or $1.00 respectively, this is so indicated by an asterisk (*).

1.4 Processing Resources Considerations

As mentioned elsewhere in this report, each individual state must make its own determination concerning the cost-effectiveness of implementing improved controls for any particular area of erroneous payments. However, one goal of the eight state assessments was to investigate the extent to which observed differences in control practices are correlated with differences in claims processing resources and costs. It should of course be stressed that any such comparison of claims processing resources is at best dangerous, due to such factors as differences in the mix of claims (e.g., drug claims may be processed with much less cost compared to hospital claims), differences in the regulations which must be enforced, differences in the scale of operations, differences in organization, etc. Additionally, processing resources are also affected by the degree of automation, and while it was possible to obtain fair estimates of the numbers of claims processing personnel, data on computer costs was often of questionable reliability (especially in those states in which Medicaid data processing facilities are shared with other state users). Nevertheless, it is of interest to note whether those states with the most comprehensive systems of controls are found to

TABLE 1

SUMMARY OF ERRONEOUS PAYMENT DETECTION ACTIVITY IN EIGHT STATES[1]

Erroneous Payment Category	*If Greater than 1.0 per 100 or $1.00 per $100
Ineligible Recipient	
Invalid number or not on file	•
Not eligible on date of service	•
Recipient name and number disagree	•
Ineligible Provider	
Invalid number or not on file	
Duplicate Claim	•
Above Allowed Reasonable Charge	•
Other Sources of Payment	
Other insurance should be billed	•
Medicare should be billed	
Medicare EOB should be attached	
Procedure or diagnosis indicates possible accident	
Recipient excess income not credited correctly	
HMO should provide service[2]	
Incorrect and/or Incomplete Claim	
Key entry error	•
Claim incomplete or additional information needed to process	•
Invalid data	•
Incorrect hospital per diem rate	•
Incorrect calculation	
Claim inconsistent with supporting documentation	
Request provider to verify apparently erroneous data	
Incorrect drug unit of measure	
Other Payments not Allowed	
Prior authorization requirements not met	•
Exceeds service frequency limitations	•
Exceeds limitations on hospital admissions or length of stay	•
Service conflicts with another related service	•
Pre or post-operative care included in fee for surgery/maternity	
Multiple or incidental surgery	
Other incidental services	
Another provider paid for same service	
Not submitted within allowed billing time	
Sterilization requirements not met	
Insufficient information to justify procedure; minimum payment allowed for procedure	
Service denied by Medicare intermediary	
Additional documentation needed to justify services or charges	
Nursing home bed held for more than allowed days while patient absent	
Private hospital room without physician's authorization	
Drug quantity dispensed less than standard	
Drug refill too early for previous quantity to be consumed	
Other services not covered in individual state	•

[1]This table is based on samples, in the eight states, of claims which were returned to providers, reduced, denied, or corrected. Erroneous payment categories have been included in this table if the number of errors detected per 100 claim line items exceeded 0.1 in at least one state, or if the dollar value of errors detected per $100 in paid claims exceeded $.10 in at least one state. If these quantities exceeded 1.0 or $1.00 respectively, this is so indicated by an asterisk (*).

[2]Applicable only in states which include Health Maintenance Organizations (Prepaid Health Plans) as part of the Medicaid program.

require significantly greater resources than other states. For this purpose, estimates were made in each state of the claims processing person-hours per 1000 claims processed, and computer costs were also investigated to some extent.

The conclusion which can be drawn from this analysis, subject to the data limitations discussed above, is that no relationship is noted between claims processing resources and the comprehensiveness of the system of controls for erroneous payments. Indeed, certain states with the most comprehensive controls were found to be at the lower end of the spectrum with regard to processing resources. It is especially interesting to note that the one state with the greatest investment in activities such as quality assurance and system evaluation and planning does not require excessive resources overall in the processing of claims.

2.0 POTENTIALLY WEAK AREAS OF ERRONEOUS PAYMENT CONTROLS

Upon reviewing the results of the eight state assessments, one may safely conclude that most of the states successfully control the most critical erroneous payment areas, such as reasonable charge, incomplete/invalid data, exact duplicates, etc. In every state, some noteworthy practices of varying degrees were observed, and many of these practices are incorporated into the suggested control techniques in Section 5. However, in every state, there was noted at least one area of significance in which controls were lacking or incomplete. The purpose of this section is to review some of these weaknesses so that the reader might recognize any problem area which may be applicable to his or her own state. Note, the order of presentation is such that the most common problems are discussed first, followed by those which were observed less frequently.

2.1 Monitoring of Erroneous Payment Controls

A weakness common to most states is the critical management function of monitoring the claims processing controls and planning for system improvement.

One aspect of such monitoring is the use of quality assurance techniques, such as sampling of paid claims, to insure that claims processing controls are being correctly and reliably implemented. Unfortunately, adequate quality assurance programs are rarely found in state Medicaid programs. Claims processing problems are generally investigated only when brought to someone's attention in the course of normal processing, usually in a random or happenstance manner. What is needed is a regular quality assurance activity which can provide key inputs to management demonstrating those areas where processing improvements may be needed. This subject is discussed in greater detail in Section 3.

A second aspect of system monitoring is that of analysis and planning for system improvements. In every claims processing system, there are some areas of erroneous payments in which controls are lacking or incomplete. It is crucial that management be aware of such control "gaps" (through conscious analysis), be informed of the quantitative magnitude of such problems (in terms of erroneous payments made), and actively consider the cost-effectiveness of implementing improved controls to reduce such problems. Additionally, it should be recognized that any Medicaid program is highly dynamic, and a control system must be capable of changing in response to changes in regulations, patterns of medical care, and learning on the part of the providers. Thus, there is a need for a management function to effect such evaluation and planning. Unfortunately, as in the case of quality assurance, in most states there is a serious lack of an adequate level of activities such as these. Emphasis is placed on the day-to-day operations of the claims processing system rather than the effective long-term management of that system. More discussion of this topic is presented in Section 4.

2.2 Duplicate Claims

Based on observations in the eight states, some of the more significant problems which occur in controlling duplicate payments are as follows:

1. A system may not be designed to detect duplicate claims which are processed during the same computer editing run.
2. A system may not detect duplicate claims which are billed under different provider numbers. This may occur, for example, as the result of billing errors in group practices or in cases where providers have separate identification numbers corresponding to multiple office locations.

3. A system may not detect duplicate claims in which different but closely-related procedure codes are used. This may occur, for example, when two different types of office visits are billed or two different versions of the same surgical procedure are billed. Usually such errors are the result of coding inconsistencies in the provider's office or by claims processing personnel (in those states where procedures are coded as part of the routine processing).
4. A system may not detect duplicate claims with overlapping dates of service. An example would be two hospital claims, the first for January 1 through January 30, the second for January 15 through February 15.
5. A system may not detect duplicate claims with different charges for the same services.
6. A system may not detect duplicate claims from different provider types, e.g., a nursing home claim and a hospital claim for the same recipient.
7. The file used for checking for duplicate claims may not be updated sufficiently fast to detect all duplicates. (Such a file should be updated with each paid claim.) In the case of one state, duplicate edits are performed manually using a CRT history which is not updated on a timely basis, resulting in duplicate payments.

2.3 Other History-Related Errors

Aside from duplicate claims, there are a significant number of possible erroneous payments which involve relationships between more than one service in paid claims history. Examples of such situations are:

1. Separate claims for pre or post-operative care associated with a major surgical procedure, when the payment for the surgical procedure is intended to include such care.
2. Separate claims for pre-natal or post-partum care, which should be included in the payment for total obstetrical care.
3. Multiple or incidental surgical procedures, where the minor procedure should be paid at a lesser rate than if performed independently, or where the payment for the major surgical procedure is intended to include payment for the minor procedure.
4. Other incidental procedures such as a surgical tray (to be included in payment for surgery) or blood pressure reading (to be included in payment for an office visit), etc.
5. Services with frequency limitations set forth by state policy (e.g., only two office visits per month without prior authorization, only one dental examination per year, etc.).
6. Multiple laboratory procedures which, in some cases, should be combined into an all-inclusive procedure to be paid at a lesser amount than the sum of the individual procedures.
7. Billing of initial office visits for visits subsequent to the first visit for a recipient for a spell of illness.
8. Readmission or split billing of hospital stay as an intentional on unintentional means for circumventing length-of-stay guidelines.
9. Drug refill occurring too soon after previous dispensing.

The control of situations such as these is among the most difficult tasks for a claims processing system, often requiring sophisticated computer edits. Most states exercise manual control over such situations in those cases where the conflicting services appear together on the same claims. However, a common weakness is the lack of such controls when the procedures are billed on more than one claim.

The reader is referred to Section 5.1 for some suggestions on methods for controlling such situations.

2.4 Cost-Reimbursement

Certain providers, most notably inpatient hospitals, are reimbursed on a reasonable cost, rather than a reasonable charge basis. This means that a payment made on an individual claim is only an interim payment, the real settlement being made at the end of the year. This mechanism leads to some rather unusual consequences that are almost universally misunderstood. Quite commonly, the organizational unit responsible for processing claims has no awareness of the consequences of its actions as they relate to the cost settlement procedures. In particular, considerations that seem important to a claims processor, such as total amount paid, may be irrelevant (when viewed as an interim payment), whereas items which appear to be less critical, such as whether the number of days is entered on the correct line (e.g., semi-private, intensive care, or nursery), can be of critical importance. To illustrate some of the difficulties which may arise:

1. In one state, it was discovered that the number of hospital days was erroneously entered as far exceeding the actual number of days. Since it was noted that the amount paid was nevertheless correct, no attempt was made by the state to adjust the number of days to the correct amount. However, the effect of this is

to show an inflated count of days for the hospital's cost audit which determines the final settlement. The result is an overpayment in the settlement. Thus, the amount paid on the individual hospital claim is of minor importance (so long as accurate records are maintained of such payments), whereas the critical data which affects the ultimate settlement is the number of days.

2. In one state, it was discovered that the number of semi-private accommodation days had been erroneously entered as intensive care days. Since it was noted that the amount paid was nevertheless correct, no attempt was made by the state to correct the error. Again, the effect of this is to show an inflated number of intensive care days for the cost audit, resulting in an overpayment at the time of settlement.

3. In one state, when refunds are received from hospitals (e.g., due to duplicate payments discovered by the hospital), no adjustment is made of the number of days accumulated for cost audit purposes. The result is again an overpayment at the time of cost settlement, due to an inflated number of days.

4. In some states, poor controls are exercised in the processing of claims for cost providers (e.g., detailed breakdowns of charges are not required and examined[1]), in the mistaken belief that such controls will be exercised in the cost audit.

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[1] In the case of one state, outpatient charges are billed without any indication of what services were provided, and such charges are not subjected to any question during claims processing.

However, such audits are typically administered under the assumption that services and charges approved in claims processing are covered and are correct. The main function of the audit is to determine provider costs, not whether individual services are correct and covered, and the charges approved in claims processing are the key data used to prorate those costs.

5. In some states, claims processing records of approved services and charges are not reconciled with the providers' records, but rather the providers' records are accepted subject to reasonableness checks. The effect of such an approach may be to pay (in the cost settlement) for certain erroneous or non-covered charges which were denied in claims processing yet still appear in the provider's tabulations.

6. In some states, claims processing tabulations of approved services and charges are found to be unreliable and may thus be useless to cost auditors or result in errors in the cost settlement.

2.5 Information Feedback

In any claims processing system, information is often available in one area of Medicaid operations that would be valuable to some other functional group not directly tied into the normal claims processing. Examples of such data include: information on a claim which is of use to the local Welfare office, such as an indication of the death of a recipient, or of medical insurance which is not on the eligibility file; information that

an attorney has requested a billing history for a liability case, of interest to the third party accident recovery unit; or a hospital claim that is denied, indicating that the corresponding physician claim needs investigation. Such feedback of information is most often overlooked in Medicaid operations, but usually would require little effort, while paying large dividends in the detection of erroneous payments. See Section 5.15 for more discussion of this subject.

2.6 Accident Liability

Most states do not have claims processing edits aimed at detecting procedures and diagnoses which are accident-related and which might indicate third-party liability. Also, in some states, there is no section of the claim form which explicitly requests accident information from the provider; accidents are detected only when so indicated by the provider in the space provided for a written diagnosis. The reader is referred to Section 5.3 for more discussion of this subject.

2.7 Other Insurance

Most states need improvement in the detection and collection of other insurance resources. Often, other insurance information is not indicated on recipient identification cards, nor is it included on the eligibility file for reference during claims processing. Also, there is often no section of the claim form which explicitly asks if the recipient has other insurance. Almost always, there are no checks for correctness or reasonableness of insurance payments or non-payments. The reader is referred to Section 5.4 for a detailed discussion of this subject.

2.8 Payments for the Wrong Recipient

A common error is the payment of claims for a valid recipient number which does not correspond to that of the actual patient. Often, payment is for the wrong member of a case and, sometimes, for the wrong case. Usually, but not always, the patient is himself eligible. However, even when the patient is eligible, such an erroneous payment results in an incorrect paid claim history, which can affect the processing of subsequent claims. The claims processing system could prevent such errors by editing the recipient number against the first two or three characters of the recipient first and last name.

2.9 Claim Adjustments

In most states, claim adjustments are not subjected to normal claim editing. As a result, the potential exists for making erroneous payments, such as exceeding reasonable charge, or duplicating a previous payment.

2.10 System Inquiry

In several states, it is extremely difficult to locate a claim in process, inquire of its status, or construct an audit trail indicating the actions taken on a claim at various stages of processing. It is often difficult to obtain useful information on a recipient's history of paid claims, as there may be no routine retrieval method or history printouts may lack critical data such as procedure codes. Such facilities are important as tools for claims reviewers while processing claims as well as for any adequate quality assurance operation (see Section 3 for more discussion of quality assurance).

2.11 Claim Form Design

In several states, there are aspects of the claim design which hinder proper control. Examples are:

1. Ambiguous data definitions; e.g., "units" could mean RVS units or number of services; "amount charged" could be amount per service or total amount.
2. Lack of clear questions which require the provider to inquire about insurance or third party liability. For example "Does the recipient have insurance? - yes - no" is preferable to "other payments" or "other sources of payment".
3. Lack of sufficient detail to determine what procedures have been performed, e.g., permitting providers to file Medicare crossover claims without an EOMB and showing only the amount of coinsurance and deductible, not the services rendered.
4. Lack of written procedure description.
5. Lack of claim entries for various cross-checking totals; e.g., sum of individual charges compared to total charges, charges per unit and number of units compared to total charges for a service.
6. Use of codes which are vulnerable to handwriting misinterpretation, e.g., D and P.

2.12 Efficiency of Processing

In several states, there are aspects of the claims processing operations which result in unnecessary manual effort. Usually, such inefficiency results from one of two causes: the computer edits may not be sufficiently refined, resulting in the suspension of certain claims which will always be approved after manual review; or, when claims are suspended, the failure to print out related data (e.g., the related duplicate claim in history) may result in unnecessary research by review personnel. The

reduction of such manual effort would permit a state to allocate resources to other areas where controls are lacking.

2.13 Edit Bypass and Override Procedures

In some states, erroneous payments are made because of bypasses or overrides which circumvent normal claims processing edits. Possible problems in this area include: the bypassing of edits to reduce processing backlogs; the failure to list all error reasons for a claim which suspends, resulting in the inadvertent override of errors which may not have been apparent to a claims reviewer; the use of very general force codes which override all edits or large classes of edits; the failure to edit claims for conflicts against previously suspended claims, so that when the latter are approved, they will have been exposed to all claims processed in the time between suspension and approval; and the failure to subject data corrections to normal claim edits. The reader is referred to Section 5.14 for more discussion.

2.14 Feedback to Providers

In some states, providers are not always informed of the reason for denied claims, or even that such claims are denied. Consequently, providers are likely to rebill deleted procedures. If the procedures were originally deleted because they conflicted with other procedures on the same claim (e.g., followup care for surgery), then the rebilled procedures may not be detected as erroneous unless the state has adequate history-related edits.

2.15 Administration of Claims Processing Controls

In some states, the claims processing operations are marked by an overall atmosphere of confusion, which is detrimental to system operations and which creates an atmosphere conducive to erroneous payments. Physically,

the operation may be marked by temporary and haphazard methods of storing and organizing documents. There may be a general confusion and lack of knowledge concerning procedures and duties, with the system lacking good written procedures and training of personnel.

2.16 Lack of Fee File

In some states, there are no maximum fee schedules for certain types of services, most significantly prescription drugs. In these cases, any amount billed will generally be paid, subject to broad maximum limits in some cases. In the case of drugs, one implication is that there is no incentive to dispense drugs by their generic name.

2.17 Length of Stay Edits

In some states, the length of stay edit incorrectly computes length of stay based upon the number of days covered in the billing period rather than the time since the admission date. Also, as discussed earlier, there are often no edits to control claim-splitting or readmission within a very short time, which might be an intentional or unintentional means for circumventing the length of stay edits.

2.18 Medicare

In some states, Medicare eligibility is not indicated on the recipient file or the recipient identification card. Thus there is no means of control for Medicare eligibles who are under the age of 65.

2.19 Other Control Problems

1. Recipient Eligibility Check for Date of Service. In one state, the recipient is checked for eligibility only for the first date of service on a claim. Thus, if a recipient's eligibility lapses in the midst of the service period indicated on a claim (e.g., for a hospital inpatient claim), the entire claim will be paid, including those periods for which the recipient is no longer eligible.

2. Recipient Cancellation Time Lag. In one state, recipient identification cards are issued only once every six months. Any claim for services during the 6 month period listed on the recipient's eligibility card will be paid regardless of whether the recipient's eligibility has been cancelled during this period.

3. Recipient Spenddown. In one state, when a medically-needy recipient satisfies his spenddown requirement as of a specific date, the eligibility file will show his eligibility as commencing on that date. However, if he subsequently presents a medical bill for service prior to that date, which has not been used as part of the spenddown requirement, the eligibility date is set backwards to the earlier date in order that the bill may be paid. After this occurrence, there is no check to insure that claims supposedly used as part of the spenddown requirement are not paid by Medicaid.

4. Provider Eligibility. In one state, there is no control over the enrollment of providers in the Medicaid program. If a claim is received from a provider who is not listed on the provider file, the provider is added to the file so that payment may be made. Also, there are no start or end dates for provider eligibility. Finally, there is only minimal control to insure that a provider is specifically qualified to render the services for which he is billing.

5. Controls on Medicare Crossover Claims. In one state, Title 18 claims do not contain sufficient information to insure that the correct amount of coinsurance/deductible is listed. (In this particular state, such claims are submitted by the provider directly to Medicaid, rather than by the Medicare Carrier or Intermediary.) No procedure information is given, so that adequate editing is not possible. For example, claims with overlapping but not identical dates of service are paid even though there is a significant

likelihood that they are duplicates.

6. Prior Authorization. In one state, prior authorizations are not matched against the corresponding claims to insure that the services performed and the charges correspond to those authorized.

3.0 QUALITY ASSURANCE PROCEDURES

Quality assurance is the mechanism by which a state may help insure that its control system is operating as it is designed and intended to operate. Quality assurance procedures are thus key in detecting errors in manual processing, computer programming bugs, problems in accurate file maintenance, faulty or error-prone processing procedures, etc. The quality assurance procedures which may be used include:

1. Sampling of paid claims to determine that all regulations have been satisfied, payments made correctly, and any recent system or regulation changes properly implemented.
2. Analysis of provider refunds or claim adjustments to determine the cause of erroneous expenditures which have been brought to the state's attention by providers.
3. Submittal of fictitious claims with the same purpose of #1.
4. Tabulation of claims rejected because of processing errors (e.g., key-entry), broken down by type of error and by personnel involved.
5. Sampling and reconciliation of reference files to insure accurate and timely maintenance.
6. Periodic review of manually-processed documents.

Quality assurance should be a central part of every claims processing operation. Unfortunately, procedures such as those above are found in relatively few states. Only one of the eight states evaluated in this study, namely Kansas, had implemented a thorough quality assurance function. (However, an informal sampling activity had been instituted in North Dakota, and a few other states indicated future plans for such activities.)

Blue Cross/Blue Shield, the fiscal intermediary in Kansas, has a very extensive and noteworthy quality assurance program. The major effort is totally separate from the claims processing operations, as it ideally should be, and, in fact, covers not only Title XIX, but all other programs run by Blue Cross/Blue Shield. It uses many of the above techniques to achieve its goal of measuring control efficacy, and detecting system deficiencies.

The Internal Audit group, responsible for quality assurance, takes a random sample of paid claims and a 100% sample of adjustments every month, and checks each for correct processing. This often involves extensive research, since claims are checked for some situations which are not normally part of the manual claims processing. This quality assurance activity is carried out by experienced former claims examiners, and a report is generated each month detailing their findings; this includes overall error rates, as well as detailed discussion and recommendations on each error found, which is communicated to the claims processing personnel.

In addition, there is further quality assurance evidenced in the claims processing area itself, where supervisors or their assistants regularly review the work of their unit, to ensure compliance with the manual procedures and policies. Approximately 10% of the documents processed are reviewed in this manner.

The post-payment utilization review unit also sometimes performs a quality assurance function in the course of its major goal of reviewing providers and recipients. In particular, an experimental program has just been started, sending an SOMB and a questionnaire to a sample of recipients. Although principally a utilization control, this type of investigation can also serve to point up system deficiencies.

An exemplary quality assurance activity may also be found in the State of California. Sampling procedures have been instituted at the MediCal Intermediary Operations (MIO), and sub-samples are analyzed by state personnel. In the past, California has also made use of a facility for submitting fictitious erroneous claims to test the entire claims processing operations (manual and computer), and has found such a procedure quite useful.

It is of interest to note that the Bureau of Health Insurance of the Social Security Administration has instituted a mandatory quality assurance program for its Title XVIII carriers, and such procedures should be of use to state Medicaid agencies.

It is important that any major quality assurance activity be separate from the day-to-day claims processing operations. In this way, quality assurance personnel are more likely to take a broader, more comprehensive view of erroneous payments, rather than being biased by existing processing procedures, which may themselves be erroneous. Additionally, separation of the quality assurance function helps insulate such personnel from the daily pressures to maintain claim throughput.

Finally, it should be noted that, in the course of the eight state assessments, the authors have engaged in various activities, such as claim sampling, of a quality assurance nature. The need for this type of activity is highlighted by a number of problems uncovered during the assessments, ranging from computer bugs to erroneously applied manual procedures.

4.0 SYSTEM EVALUATION AND PLANNING

In every claims processing system there are some areas of erroneous payments in which controls are lacking or incomplete. The absence of controls in certain areas, however, should not by itself be considered a system deficiency, as it may not be cost effective to implement controls in every area. What can be considered a deficiency is a state's lack of awareness of the control "gaps", of their seriousness (in terms of erroneous payments made), or of the cost-effectiveness of implementing improved controls.

Thus, an important aspect of the managing of a state's control system is the process by which decisions are made to modify the control system, i.e., to introduce new claim edits or to eliminate existing controls. Two key considerations in this process are the cost incurred by implementing and operating the particular edit (manual and/or computer) and the program dollar savings resulting from the control (including deterrence of erroneous claims). Hopefully, a quantitative comparison is made between these costs and benefits and the information is used in the decision-making process.

Even in those cases where a specific decision is not anticipated, there is a need for information indicating the extent of erroneous payments in areas which a state knowingly lacks controls. Such information provides a sound basis for planning and is crucial for monitoring any problem areas arising in the system operations.

The control of erroneous payments is a dynamic process. Not only do regulations change, as program changes are made, but learning takes place by providers and recipients that necessitate changes in the emphasis of the controls. The learning has a positive aspect as it is the basis of the deterrent effect whereby erroneous claims are not submitted. On the other

hand, erroneous claims may increase over time in those areas where controls are absent or weak. For these reasons, an effective control system must have built in methods of discovering these changes and reacting to them to correct deficiencies. By using methods such as sampling paid claims to discover deficiencies, a state can uncover those areas in which stronger controls are needed, as well as places where excessive effort is expended for little return. Caution must be exercised, however, as the small apparent return in some areas may be a result of the deterrence of the existing control.

Finally, similar quantitative analyses can be utilized to improve the efficiency of the processing system. By sampling claims suspended by the computer for manual review and by noting the decision criteria used during claim correction, computer edits can be refined so that cases of unnecessary rejections are eliminated. In this way, processing costs can be reduced without any adverse effect on erroneous payments.

In most states, there is a serious lack of an adequate level of such evaluation and planning activities. As in the case of quality assurance, this management function is typically lacking as resources are concentrated on the day-to-day claims processing operations. Management personnel are often aware of control deficiencies, yet have made no attempt to estimate the magnitude of erroneous payments resulting from such deficiencies. In some cases, conscious decisions have been made not to implement improved system controls or to relax existing controls, and such decisions have been made without a quantitative consideration of potential program dollars saved due to the controls.

Note, it is not being suggested that states implement an extensive analytical capability, but rather that some quantitative analyses be carried out at an appropriate level considering program size. Such analyses

could be viewed as extensions of a quality assurance program, with a good part of the quantitative data provided through such quality assurance. (The feasibility of this is illustrated in the state of Kansas, where the quality assurance, or internal audit, group on occasion undertakes special studies to evaluate particular areas where controls may be lacking.) Note, an initial task of such a system evaluation group could be a thorough analysis of the state's controls in light of the erroneous payment checklist in the Appendix.

5.0 SOME SUGGESTED CONTROL TECHNIQUES

In this section, we present a number of techniques which may be used to control some of the erroneous payment situations of the Appendix. The techniques discussed here been selected based on their applicability to a variety of states and based on certain unique or non-obvious features. That is, the reader of the Appendix would not naturally arrive at such techniques as the obvious method of control. In many cases, the techniques have been observed in operation in a state, and state references have been cited where appropriate. In other cases, the techniques are the result of accumulated experience with erroneous payments in several states.

5.1 Detection of History-Related Errors

Aside from duplicate claims, there are a significant number of possible erroneous payments which involve relationships between more than one service in paid claims history. Examples of such situations are:

1. Separate claims for pre or post-operative care associated with a major surgical procedure, when the payment for the surgical procedure is intended to include such care.
2. Separate claims for pre-natal or post-partum care which should be included in the payment for total obstetrical care.
3. Multiple or incidental surgical procedures, where the minor procedure should be paid at a lesser rate than if performed independently, or where the payment for the major surgical procedure is intended to include payment for the minor procedure.
4. Other incidental procedures such as a surgical tray (to be included in payment for surgery) or blood pressure reading (to be included in payment for an office visit), etc.

5. Services with frequency limitations set forth by state policy (e.g., only two office visits per month without prior authorization, only one dental examination per year, etc.).
6. Multiple laboratory procedures which, in some cases, should be combined into an all-inclusive procedure to be paid at a lesser amount than the sum of the individual procedures.
7. Billing of initial office visits for visits subsequent to the first visit for a recipient for a spell of illness.
8. Readmission or split billing of hospital stay as an intentional or unintentional means for circumventing length of stay guidelines.
9. Drug refill occurring too soon after previous refill or prescription.

The control of situations such as these is among the most difficult tasks for a claims processing system, often requiring sophisticated computer edits. Most states exercise manual control over such situations in those cases where the conflicting services appear together on the same claim (this is more likely to occur, for example, in the case of multiple laboratory procedures than for pre or post-operative care). However, a common weakness is the lack of such controls when the procedures are billed on more than one claim.

Given that a state determines that it is cost-effective to implement computer edits to detect some or all of these situations, it should be noted that a small number of versatile table-driven edits can often suffice to control most such situations. Possible formats for such edits are given in the following two sub-sections. Finally, there are some clever manual

procedures which can serve similar functions to prevent some of these erroneous payments, and some of these manual procedures are also discussed below.

5.1.1 Table Driven Combination Edits

A particularly effective method of handling most of these situations is used by the State of Virginia. The logic is very general, with the specific edit situations being defined in a table. The table format is as shown in Figure 1. Each row of the table specifies criteria for an individual edit. The first column specifies the type of invoice such as physician, dentist, etc. The third and fourth columns specify a range of procedure codes. If the procedure code for the claim being processed falls within this range, then the edit defined by the row in the table will be applied. The fifth and sixth columns specify another range of procedure codes. If a second service is found, in paid claims history or on the claim being processed, which falls within this range, then the subject claim may fail the edit provided that the criteria in columns 7 through 14 are met. Column 7 indicates any special provider specialties to be excluded, usually an anestheseologist using the same code as the surgeon. Columns 8 and 9 indicate the number of days within which to search for the second code and whether to search before the date of the subject procedure, after, or in either direction. Columns 10 and 11 indicate how many occurrences of the second procedure are needed for the edit to fail. Column 12 allows a dollar limit to be placed on the edit so that claims totalling less than this limit will not be suspended, and column 13 indicates whether an overlap in dates between the two claims is permitted or not. Finally, the last two columns indicate the action to be taken if the claim fails the edit.

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RMH020 COMBINATION EDIT TABLE MAINTENANCE REPORT

ACTIVITY	INVO TYPE	REC SEQ	INPUT-CODES FROM	INPUT-CODES TO	HISTORY-CODES FROM	HISTORY-CODES TO	SAME-ANY PROVIDER	EXCLUDE PROVIDER	DAYS NO	DAYS CO	OCCURS NO	OCCURS CD	DOLLAR LIMIT	CLAIM OVLAP	ACTION CODE	DEFAULT CODE
MISSING OR INVALID DATA - CARD NOT PROCESSED						RMH020R										
	05	0010	00101	06039	00101	06039	S	57	001	E	002	1	0000	N	PEN	PAY
	05	0020	00101	06039	00101	06039	A	57	001	E	001		0200	N	PEN	PAY
	05	0030	00101	06039	02111	02111	S	57	001	E	001		0000	N	PEN	PAY
	05	0040	00101	06039	02124	02124	S	57	001	E	001		0000	N	PEN	PAY
	05	0050	00101	06039	03121	03121	S	57	001	E	001		0000	N	PEN	PAY
	05	0060	00101	06039	03126	03126	S	57	001	E	001		0000	N	PEN	PAY
	05	0070	00101	06039	03251	03279	S	57	001	E	001		0000	N	PEN	PAY
	05	0080	00101	06039	03301	03302	S	57	001	E	001		0000	N	PEN	PAY
	05	0090	00101	06039	03931	03932	S	57	001	E	001		0000	N	PEN	PAY
	05	0100	00441	00441	00445	00479	S	57	001	E	001		0000	N	DEN	PAY
	05	0110	00445	00479	00441	00441	S	57	001	E	001		0000	N	PEN	PAY
	05	0120	02111	02111	00101	06039	S	57	001	E	001		0000	N	PEN	PAY
	05	0130	02124	02124	00101	06039	S	57	001	E	001		0000	N	PEN	PAY
	05	0140	03121	03121	00101	06039	S	57	001	E	001		0000	N	PEN	PAY
	05	0150	03126	03126	00101	06039	S	57	001	E	001		0000	N	PEN	PAY
	05	0160	03251	03279	00101	06039	S	57	001	E	001		0000	N	PEN	PAY
	05	0170	03301	03302	00101	06039	S	57	001	E	001		0000	N	PEN	PAY
	05	0180	03931	03932	00101	06039	S	57	001	E	001		0000	N	PEN	PAY
	05	0190	04614	04631	04647	04669	S	57	001	E	001		0000	N	PEN	PAY
	05	0200	04647	04669	04614	04631	S	57	001	E	001		0000	N	DEN	PAY
	05	0210	04820	04823	09001	09003	S	57	187	A	001		0000	N	PEN	PAY
	05	0220	09001	09001	09002	09003	S		001	E	001		0000	N	PEN	PAY
	05	0230	09001	09003	04820	04823	S	57	187	B	001		0000	N	PEN	PAY
	05	0240	09001	09036	09050	09051	S		001	E	001		0000	N	DEN	PAY
	05	0250	09001	09051	09060	09061	S		001	E	001		0000	N	PEN	PAY
	05	0260	09002	09003	09001	09001	S		001	E	001		0000	N	DEN	PAY
	05	0270	09010	09010	09010	09010	S		001	E	001		0000	N	PEN	PAY
	05	0280	09010	09010	09015	09015	S		001	E	001		0000	N	PEN	PAY
	05	0290	09015	09015	09010	09010	S		001	E	001		0000	N	PEN	PAY
	05	0300	09015	09015	09015	09015	S		001	E	001		0000	N	PEN	PAY
	05	0310	09030	09030	09030	09030	S		001	E	001		0000	N	PEN	PAY
	05	0320	09030	09030	09036	09036	S		001	E	001		0000	N	PEN	PAY
	05	0330	09036	09036	09030	09030	S		001	E	001		0000	N	PEN	PAY
	05	0340	09036	09036	09036	09036	S		001	E	001		0000	N	PEN	PAY
	05	0350	09050	09051	09001	09036	S		001	E	001		0000	N	PEN	PAY
	05	0360	09050	09051	09050	09051	S		001	E	001		0000	N	DEN	PAY
	05	0370	09050	09051	09050	09051	A		001	E	002	1	0000	N	PEN	PAY
	05	0380	09060	09061	09001	09051	S		001	E	001		0000	N	PEN	PAY

Figure 1: Format of Combination Edit Table

Note that virtually all of the history-related situations noted above can be detected by the appropriate specification of the table parameters. Furthermore, the table criteria permit a flexible specification of the edits so that such edits can be made highly efficient, i.e., suspending only those claims most likely to be erroneous. Also, because ranges of procedures can be edited against a different range of procedures (such as all surgical procedures against all physician visits), the table can be made very compact. A final major advantage of this system is the ease with which the edit can be understood by non-computer personnel. In fact, in Virginia, the file is changed on-line by senior Medicaid personnel. This enables edits to be introduced or eliminated very quickly and easily, and with a good system for measuring the effect of an edit (in terms of claims suspended and reduced or denied), simplifies the decision on whether an edit should be kept.

Note that table-driven edits such as those discussed above can also be used to detect near duplicate claims. (Conversely, near duplicate edits may detect many of the situations above.) While this may not be the most efficient method of detecting all near duplicates, it would seem to be a highly effective method for certain types, such as claims with closely-related procedures (e.g., two different types of visits or two versions of the same surgical procedure).

5.1.2 Table-Driven Limitation Edits

Combination edits such as those described above may be used to detect violations of frequency limitations on various services. However, if there are a large number of procedures with different limitations, it may be more efficient computationally to implement a special limitation edit which uses as data a table specifying the limitations for each procedure.

Such a system has been implemented also in the State of Virginia. Service limitations are specified in the same file which specifies maximum payable fees for each procedure. (Additionally, other procedure restrictions are specified such as age, sex, prior authorization, etc.) As in the case of the combination edits, a chief advantage is the ease with which edit criteria can be changed, without any need to modify computer programs.

5.1.3 Manual Detection Methods

In some cases, clever manual detection methods can achieve much the same results as sophisticated computer edits for history-related situations. Examples are:

1. Blue Cross/Blue Shield of Kansas, the intermediary for the Kansas Medicaid program has a particularly effective method for detecting pre and post-operative care without computer edits. The procedure is to specially route all physician hospital visits to a special group for investigation. The diagnosis is used to determine if it is likely that surgery was performed, and the appropriate claims are retrieved from history. (An on-line history is available for inquiry.) If a surgery claim has not yet been received, the claim(s) in question will be held for a period of time to await any surgery claim. This technique also detects concurrent care in the hospital by two physicians. Major surgery, multiple surgery on the same claim, and assistant surgery are also routed to the same group, and they are responsible for collecting all claims, including the hospital claim, for review by the utilization review committee. All such claims are reviewed at the same time, so that the review committee

has all appropriate information available, and can make consistent and efficient decisions on disposition of such cases.

The technique described above for pre and post-operative care is dependent on the ability to inquire easily into paid claim history. Also, a state would not be able to detect followup care in the office using the same technique.

2. In the State of North Dakota, any claims for pre-natal care are recorded in a special notebook (such claims are detected by noting the procedure billed or the diagnosis). When the claim for obstetrical delivery is received, the previously-gathered information is used to adjust the amount paid, with due consideration of whether the delivery was performed by the same or a different provider.

3. In the State of North Dakota, claims for payment originate in the local Welfare office. When a provider wishes to bill for services, he contacts the local office, which provides him with a claim form, called an 'authorization', on which recipient data is entered after eligibility has been checked. Providers are encouraged to bill all services in a month on the same form, and if a duplicate authorization is issued, the local office is expected to maintain a close control over it. Such a system helps to control multiple procedures, followup visits, etc. as such services would tend to be all on the same authorization. The system additionally provides a control for exact and near duplicates.

While such a system would only appear feasible in a very small state, it does suggest the concept (appropriate for any state) of requiring all services for a period (e.g., a month) to be billed on a single claim, thus facilitating the manual control of history-related situations.

4. In the State of Georgia, claims are examined for any hint that the services are related to surgery or maternity. The chief method of detection is through the diagnosis or the written procedure. If there is some likelihood of surgery or maternity but it is not entirely clear from the claim, more information is requested from the provider.

5. In the same spirit as #3 and #4 above, a state can often control certain history-related situations by a clever design of the claim form. For example, detection of pre or post-operative care can be facilitated by questions such as:

Is this care related to surgery? ___YES ___ NO

If yes, surgical procedure _____, date _____,

surgeon _____

Detection of pre-natal or post-partum care can be aided by the following questions:

Is this care related to pregnancy? ___YES ___ NO

If yes, date or expected date of delivery _____

attending physician _____

Multiple or incidental procedures or laboratory combinations may be detected as follows:

Have other services been provided for this recipient on the same day as any of the above procedures?

___ YES ___ NO

If yes, provide details _____

_____

In considering the above suggestions, the following observations should be made:

a) These techniques of claim form design have not been observed by the authors in any state, so that their effectiveness is untested.

b) The controls depend on the accurate responses given by providers.

c) Provider relations will be upset by an overly-ambitious push in this direction. On the other hand, most of the above questions are designed such that a simple checked "no" is all that will be required for the great majority of providers' claims.

5.2 Incorrect and/or Incomplete Claim Data

There are basically two aspects to this category of errors. The first is erroneous data on the claim itself, usually arising from provider error, such as incorrect ID numbers, incorrectly coded procedures, etc., or data missing, including attachments such as medical reports or itemized bills. The second aspect concerns that of entering the data correctly for computer processing.

The first type of error may be controlled partly manually by pre-auditting and partly by computer checks, although any error detected by the computer checks could equally well be a result of entry error. The second type of error can only be adequately controlled by edits internal to the computer. The following are descriptions of various techniques for detecting certain kinds of errors.

5.2.1 Manual Edit

There are no special techniques. A simple checklist of all items that must be on the claim provides a basis for checking completeness of the claim. Manual edits can also insure that procedure and diagnosis codes, when entered by the provider, are consistent with any written descriptions.

5.2.2 Verification

The verification of input data has become something of a tradition in data processing. This tradition arose from the use of punched cards, on which it was impossible to directly check if the data was correctly punched. However, with modern techniques of key-tape data entry, with instant feedback in the form of a CRT display, there is some question as to the usefulness of this practice. Although verification will reduce errors somewhat, the verifier will tend to mis-read the data in the same way as the original key-entry operator, resulting in a significant irreducible error-rate that must be detected during initial processing.

5.2.3 Data Validity Edits During Claim Entry

In many states, claims are entered onto tape or disc from a CRT terminal via a stand-alone mini-computer. Such a mini-computer can be programmed to screen for data which is invalid, out of range, or internally inconsistent. Thus, entry errors can be corrected on the spot, reducing the number of claims rejected during the main computer processing. Key verification, if desired, can be performed on the same entry system.

It is common practice that any edits programmed into such an entry system, as well as any manual checks for claim completeness, are repeated in the main computer processing, to prevent payment of erroneous claims which have been overlooked during manual screening or force-entered by key entry operations.

5.2.4 Variance Edits

Variance edits are used to detect claims in which the amount billed differs significantly from the amount allowed. By rejecting claims with charges that fall outside a specified range around the expected charges, a variety of errors can be detected, including key-entry, incorrect procedure code, incorrect charge, etc.

The concept of variance edits could also be applied to other data elements, besides charge, where there is a well-defined value expected for the data on the claim.

5.2.5 Reasonableness Checks

There are a variety of logical relationships that should normally occur between different items of data and there are often reasonable ranges in which data elements should fall. These can be made the basis for reasonableness checks. Examples include:

1. Procedure can be checked for consistency with diagnosis, age, sex, specialty, place of service, and provider type (e.g., an abortion would not be a correct procedure for a male, or for a 2 year-old child; an eye operation would not normally be performed by a gynecologist).
2. Similarly, diagnosis can be checked against age and sex.
3. Maximum and minimum "reasonable" ranges may be established for certain charges which lack a set fee schedule, such as hospital ancillary charges. Claims which fall outside of these ranges may be suspended to determine whether there are errors. Maximum and minimum ranges are also useful to detect errors such as incorrect billing units for drugs (e.g., tablets instead of bottles).[1]
4. Time sequence can be checked for reasonableness (e.g., admission date prior to discharge date; date of service prior to processing date, etc.).

5.2.6 Arithmetical Checks

All arithmetic on the claim can be checked for proper balance. For example:

1. number of days x per diem rate = total room charge,
2. total billed amount = sum of individual charges,
3. total number of billed days = difference between 'from' and 'to' dates,
4. number of services x charges per service = total charge for service.

The claim form can be designed to facilitate checks such as these.

[1] Another method for detecting drug billing errors is to require the provider to indicate the unit of measure by a standard (2 character) abbreviation and to check such units against a drug reference file. Such a technique has been successfully implemented in the State of Georgia.

5.2.7 Checks on Recipient and Provider Names

The majority of states capture only the recipient ID number and assume that a correct number is a valid indication of eligibility. Unfortunately, it is very possible for clerical errors to occur resulting in the wrong ID number being used. In many cases this is the number for someone else who is also eligible (often in the same family), in which case the error creates problems in maintaining accurate claim histories needed for duplicate and other edits. It can also happen that there is no connection whatsoever between the recipient and a valid identification number, so that payment is made for persons who are not eligible for Medicaid. Check digits will not detect this type of error.

The best way of confirming eligibility is to capture the first one, two, or three letters of the last name and preferably of the first name as well (to distinguish between family members). The date of birth is also useful for cross-checking, particularly in the case where two family members have the same first and last names (such as mother and daughter). Care must be taken in applying this edit, as often children have a last name that is different from the mother, or case name, and a match should be attempted against case name as well. It is advisable to suspend such situations for manual resolution, but a detailed description of matching and non-matching names on the reject listing will normally enable a rapid and routine resolution to be made.

Similar edits can be performed to check provider ID against provider name, although errors of this type are less likely than the corresponding recipient errors.

5.2.8 Post Processing Check (Warrant Control)

A manual check can be carried out at the end of processing by comparing warrant and remittance advice manually with the approved claim.

This is, of course, only feasible with certain types of claim control systems which facilitate matching up claim and warrant. Such a control is effectively a 100% sample quality assurance check for a very limited set of possible errors. If other components of the processing system are adequate, it is of doubtful value as a control mechanism.

5.2.9 Plastic ID Cards

Certain states have issued recipients plastic cards with case name and ID number imprinted as with credit cards. These cards are for identification only and do not entitle the holder to program benefits; a monthly ID card is issued for this purpose. However, the use of the plastic card with a credit card imprinter reduces considerably the number of errors resulting from mis-copying ID numbers and other recipient information. There is also the possibility of making the imprinted name and number machine-readable.

5.2.10 Pre-Printed Claim Forms

Several states issue claim forms which are pre-printed with provider ID, name, and address. This is one effective method for reducing errors in recording such provider information. A variation of this system is to issue rubber stamps to providers having all of the appropriate data; or to make use of an imprinter in conjunction with a plastic ID card.

5.3 Third-Party Accident Liability

The detection of possible third-party liability for Medicaid payment as a result of an accident, or other cause, is one of the most difficult tasks facing a state Medicaid agency. One can surmise that no matter how sophisticated a system is used, there will always be a few situations that can never be detected, in which some third party is legally liable for payment.

There are some regulatory and statutory steps that can be taken to encourage disclosure of other liability. For instance, one state has a statutory lien against any attorney handling a liability case in which Medicaid payments are involved. Thus, in any case that is settled without the state's knowledge and that later comes to light, the state collects directly from the attorney. This provision strongly encourages attorneys to advise the state of pending cases, and to ensure that Medicaid is reimbursed correctly. Naturally it is strongly disliked and opposed by the legal profession!

Some of the control methods to detect and collect third party payments for accidents are described in the paragraphs that follow.

5.3.1 Claim Form Design

By a proper selection of questions on the claim form, and by insisting that such questions are properly answered, a great deal of information can be acquired. An ideal question format is as follows:

Is this case the result of an accident? ___ YES ___ NO

If yes, was it ___ Motor Vehicle ___ Work-related ___Other?

Briefly describe circumstances _____

_____

Note that the yes/no question must be marked either yes or no on every

single claim, in order for this system to be effective, and if not, the claim must be returned to the provider for completion. The second question is not essential, but gives valuable information for use during follow-up. Additionally, a state can require that an accident information form be attached whenever a "yes" answer is given.

5.3.2 Claims Processing Procedures

There are certain claims processing edits that can be usefully applied to detect possible third party accident liability; they are:

1. suspending "traumatic diagnoses" (hospitals),
2. suspending "traumatic procedures" (physicians),
3. suspending emergency ambulance services,
4. suspending multiple procedures (physicians).

It must be emphasized that the edits described in the following paragraphs are not mutually exclusive. Many, or perhaps most, accident situations would be detected by more than one of these edits. On the other hand, the more edits of this kind that are available, the less likely it is that accident liability cases will pass through undetected.

5.3.2.1 Suspending Traumatic Diagnoses and Procedures

The purpose of such edits is to flag those situations most likely to result from an accident, by selecting diagnoses such as "lacerations" or "fractures", etc. or the procedures normally resulting from them such as "suture of laceration" or "reduction of fracture". The State of Nebraska has implemented such edits on diagnoses for hospital claims and has found these controls to be very effective. Edits to detect traumatic procedures on physician claims were planned but not yet implemented as of November 1975, so that the effectiveness of such edits has not yet been demonstrated. However, it is likely that a general "traumatic" procedure code

edit may be unwieldy, producing too many small claims with no possibility of recovery. A very select group of procedure codes would be necessary for a manageable edit.

There are also certain diagnoses, such as "black lung", that are usually work-related. It can be valuable to suspend such claims for investigation of Worker's Compensation.

5.3.2.2 Suspending all Emergency Ambulance Claims

The purpose of such edits is to uncover additional information which may be indicative of accidents. The disadvantage of such edits is the number of non-accident problems that will also require examination. If diagnosis is available, this can be used for refinement of the edit to eliminate these claims from consideration.

5.3.2.3 Multiple Procedures

In most states, multiple surgical procedures must be manually priced, so that there is ideally some method for referring such situations for review. (Unfortunately, in many states, such situations are not detected when the multiple procedures are billed on separate claim forms.) It is valuable to include in this review a screening for possible accident-related injuries, since accidents, particularly automobile accidents, often result in injuries requiring complicated multiple procedures.

5.3.3 Investigation of Third Party Liability Claims

Most of the methods described above detect only the possibility of third party liability. Many of these claims will have no third party liability, and it is therefore important to have an efficient initial screen to discriminate between them.

The screening requires the services of a specialist, most likely an insurance investigator. Depending on the size of the state, this may require one person part-time or full-time, or even more than one person in a large

state. This person would also normally carry out detailed investigation of those cases determined likely to involve a possible liability payment, and could also handle health insurance investigations, depending on workload and qualifications.

Most cases can be rapidly resolved on the basis of a phone-call to the recipient, or the parents, inquiring about the circumstances. Clearly this investigator needs tact, imagination, and considerable experience in liability cases, to consider all possible sources of payment.

The State of Nebraska does a particularly thorough job of following-up such sources of payment. The following types of information are checked:

1. Was the injury work related, and if so, do workmen's compensation laws apply?
2. Did the injury occur in a car accident? The circumstances of the accident are determined to see if a third party was negligent. Even if no liability is found, checks are made for medical payments insurance on the car in which the recipient was riding. If the recipient is injured in someone else's car, the extended medical payments on any car owned by the recipient and family members are checked.
3. Assaults are referred to the district attorney's office for prosecution and restitution of medical fees.
4. Injuries on residential or farm premises are examined for liability of the owner or tenant. If no liability is present, the possibility of medical payment coverage is considered.
5. For all other injuries, negligence by any person other than the recipient is checked.

It is most important to note that whenever one claim is found as a likely candidate for third party payment, all other claims for this recipient should be investigated for possible connection with the incident. All the methods of detection are based on finding particular types of claims, and cannot be expected to find all of the claims that may be candidates for third party payment. This is one instance where the capability to flag all claims for a particular recipient for manual review can be very useful.

Particular thought should be given to the possibility of subrogating claims, either by statute or by contract when recipients apply for welfare. Otherwise Medicaid is dependent on the recipient to initiate legal action before any recourse can be had to possible third parties. Of course, there are political pros and cons to subrogation which must also be considered.

5.4 Health Insurance

The detection of other health insurance, and its application to the medical expenses of Medicaid recipients, is generally not well carried out in most states, and is complicated by the necessity for special procedures apart from the normal claims processing operations. However, it is possible, without great complication or resources, to set up an effective system that will detect as many health insurance cases as possible. A comprehensive system for controlling health insurance is described in the following paragraphs. The feasibility of most of these techniques has been demonstrated in various states. Indeed, the state of Oregon has adopted a majority of these methods and has demonstrated the cost-effectiveness of such a comprehensive system.

5.4.1 Collection of Insurance Data

Data on other health insurance comes principally from the recipient and must be collected by the social worker at the time of eligibility determination. In the state of Oregon, a special form is completed when other insurance is indicated. This form is sent to the central claims processing department and manually filed with the insurance group. It is feasible that this data could be held on a computer file in a large state; however, a considerable amount of 'free-format' information is needed, and an advanced computer system would be required.

The data that is collected for health insurance purposes includes the following:

- name of insurance company or companies;
- ID number of insurance policy or policies;
- outline of coverage (e.g., Medical, hospital, lab-tests, major medical, other);
- Names and ID numbers of recipients covered.

5.4.2 Data on Insurance Policies

A manual file should be maintained of all major standard policies with details of coverage, as well as minor policies as deemed appropriate. In addition, personnel in the insurance group should maintain good relationships with the major insurance carriers, enabling them to check details of coverage, whether policies are current, etc.

5.4.3 Computer File (Eligibility) on Insurance

A crucial part of the system is the maintenance of data for each recipient on insurance coverage for the purpose of claims processing edits. This data is usually most conveniently associated with the eligibility file.[1] The data should indicate whether coverage is for physician, hospital, dentist, etc., so that the suspending of claims for insurance investigation can be carried out efficiently - there is no point in suspending every physician claim if recipient is covered for hospital care only. All claims that have no insurance payment shown, but for which the insurance coverage is indicated on the file, should be suspended for investigation.

5.4.4 Insurance Data for the Provider

Insurance data such as type of coverage, etc., should be communicated to the provider by printing such information on the eligibility card. Also, the provider should be required to inquire about insurance at the time the recipient is treated. Evidence of such inquiry should be in the form of a mandatory yes/no question on the claim form which asks whether

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[1] Some states do not use an eligibility file during claims processing. If eligibility "coupons" or "labels" are used (i.e., to be attached to the claim), the insurance data can be printed on these coupons. If eligibility is certified by the welfare office for each individual claim (in very small states) insurance data can be entered on the claim at that time.

there is any insurance and if so, what coverage. The response to such a question can be edited against the insurance data maintained by the state, so that inconsistencies may be resolved. Note that the yes/no question must be marked either yes or no on every claim, in order for this system to be effective, and, if not, the claim must be returned to the provider for completion. Only in this way can it be assured that the provider has asked the recipient about coverage and has informed the state if such coverage exists. It is not acceptable merely to ask the provider to indicate other payments, since this may be ignored by the provider or alternatively the provider may bill other insurance and not inform Medicaid until the time that collection is made. On the other hand, a yes/no question (with emphasis on the need for a separate "no" box) cannot be ignored.

5.4.5 Investigate All Insurance Claims

Any claim that shows an amount paid by other insurance should be routed to the insurance group. In combination with the eligibility file edit mentioned above, this ensures that all possible insurance is manually investigated.

A state may not wish to examine manually all cases where there is an insurance payment. As an alternative, such claims may be sampled to determine that insurance payments are reasonable and correct. Sampling can be biased toward high-dollar claims, and reasonableness edits can be instituted to insure that cases of suspected unreasonable payments are included in the sample. If such sampling indicates a fair amount of erroneous insurance payments, the state can revert to the procedure of examining all insurance payments manually.

5.4.6 Requirement of Insurance Explanation of Benefits or Reject Letter

Whenever the state's file indicates a recipient has

insurance, providers should be required to submit an insurance explanation of benefits or reject letter (indicating no coverage) to substantiate insurance payments or lack thereof. If a rejection letter is received, it should be used by the state to correct coverage information, after appropriate followup.

As an alternative to the reject letter, a state may wish to accept a provider statement that insurance is no longer in force. In this latter case, such claims should be audited on a sample basis to determine the accuracy of such statements. If problems are apparent, reject letters should be required (perhaps only for certain providers).

5.4.7 All Insurance Payments Checked for Reasonableness

Many states will accept any payment as fulfillment of the resources requirements, regardless of whether it is reasonable (e.g., $1.00 insurance against a $3,000 hospital claim). From the file of insurance policies, and from contacts in the insurance companies, the reasonableness of the payment can be determined, and the claim returned to the provider if appropriate, with all pertinent information, including carrier, policy number, coverage, etc.

Insurance payments which appear "reasonable" may still be inaccurate. Such payments can be audited on a sample basis to determine accuracy. If there are significant problems apparent, it may then be desirable to audit all payments of large claims for selected insurance companies.

5.4.8 Strong Rejection Policy

Because of the extensive and up-to-date files, the information on insurance will hopefully be reliable, and can be used as a basis for strong policy regarding rejection of claims. Such a policy insures that if insurance resources are available, they will be billed, or evidence will be presented to dispute the insurance coverage.

If a state permits a provider to bill Medicaid when an insurance payment is not received within a specified time, controls must also be instituted to insure that such time limits are enforced and that there is routine followup of the case with the provider and the insurance company.

5.4.9 Insurance Data Collected from Providers

Occasionally, a claim is submitted that shows an insurance payment, but for which there is no indication on the insurance file. This data must be forwarded to the appropriate department, usually the social worker, for followup. This type of situation can arise when, for example, children are covered under a labor union policy, even when the member is not working or when the parents are divorced. The recipients may not be aware of the coverage, but the family doctor may well have this information.

5.4.10 Summary

To summarize, a comprehensive system of controls for health insurance contains the following elements:

a) A manual file containing details of insurance including policy number and coverage, prepared at the time the recipient applies for public assistance or Medicaid.

b) A manual file containing all major standard insurance policies with details of coverage.

c) Data on the eligibility file to indicate recipients with other insurance and computer edits to suspend any claims for such recipients that show no insurance payment.

d) A manual or computer procedure that routes all claims showing other insurance payments to the insurance unit.

e) Communication of insurance information for recipients to providers.

f) Requirement for providers to indicate if there is other insurance through a yes/no question on the claim form.

g) Requirement of submitting insurance explanation of benefits or insurance reject letter with Medicaid claims.

h) A policy of checking the reasonableness and accuracy of insurance payments against the policy benefits.

i) A strong policy of rejecting claims which do not have the required documentation or which have not met the requirements of billing insurance resources.

j) Followup procedures for cases in which insurance companies have been billed but payment not yet received.

k) Utilization of claim information to revise any inaccurate or out-of-date data on the insurance file.

5.5 Control of Recipient Spenddown

One problem associated with the spenddown requirement is that of ensuring that the patient has actually paid the bills he is responsible for and that they are not submitted later and paid by Medicaid. This can happen as eligibility may start before these bills are incurred so that other bills can be paid. For example, the patient may be required to pay the physician bill, with Medicaid paying the hospital bill and all other services. A problem thus arises when the bills used for spenddown are not for the earliest dates of service; hence the effective eligibility date must be set earlier than the dates for the spenddown services, so that the claims not covered by spenddown may be paid.

The State of Nebraska has an noteworthy method of handling this problem. When the welfare worker determines eligibility and the bills that will be paid by the patient, he generates "pseudo-claims" that are entered into the paid claims history, but not paid. They are specially flagged as being part of the spenddown requirement. If a provider attempts to bill Medicaid for part or all of these services, his claim will reject as a duplicate of an "already paid" bill. In this way eligibility can start prior to this service date, with the confidence that "spenddown bills" will always be detected.

5.6 Unique Recipient Number

In most states, case numbers are assigned to recipients by the counties and typically are changed whenever the recipient moves to a different county or changes aid categories. Such a lack of a unique identification number hinders effective claims processing, especially that processing which is concerned with a recipient's paid claims history (e.g., duplicate edits).

In the State of Georgia, each Medicaid recipient is assigned a unique number (in addition to the county-assigned case number), which remains unchanged if the recipient changes counties or aid categories. Thus, all paid claims history for a recipient is linked, which facilitates more accurate claims processing (e.g., for duplicate and other history-related edits) and more effective Surveillance and Utilization Review.

5.7 Prior Authorization File

In order to control utilization, some states require certain procedures or types of services, such as hospital admissions, dental work, eyeglasses, etc., to be authorized prior to service. One method of confirming that the authorization was obtained is to require it to be submitted with the claim. This method has the advantage of being simple but has two disadvantages: first, it requires a thorough manual check, which can become complex when, for example, extensive dental work is authorized and billed on multiple claims; and secondly, there is the embarrassing possibility of authorizing services which may later be denied for such reasons as eligibility, non-covered procedures, etc.

The State of Virginia has a particularly effective method of dealing with these problems. When processing a claim for a procedure which requires prior authorization, the claim is matched, procedure by procedure, against a prior authorization previously placed on a computer file. These prior authorization records themselves have already been exposed to many edits similar to those used in claims processing and generally have a limited period of validity. For example, prior authorizations are edited for provider and recipient eligibility, data validity, restrictions on the service (e.g., required dental quadrant, age restrictions) whether the service is covered, etc. This method of controlling prior authorization facilitates more thorough and less error-prone processing than in other states which rely on a manual system to review prior authorization attachments.

5.8 Nursing-Home Claims

There is one common method of handling nursing home claims that is used in the majority of states evaluated for this study. This is the method whereby a "turnaround" claim is computer-generated by the state and simply certified by the nursing home operator. This method is capable of keeping errors to a minimum; however, it is essential that controls exist to ensure correct generation of these billing documents.

5.8.1 Turnaround Nursing Home Claims

Examples of turn-around claims are given in Figures 2 and 3. It can be seen that one line or section is allocated to each recipient and includes data such as recipient name and ID, "to" and "from" dates of services, level of care, payment rate, recipient contribution and resulting payment by the state. The claim has the usual space for signature by the nursing home representative, who is responsible for making any changes that have occurred during the previous month, such as admission, discharges, etc.

5.8.2 Initiating Turn-around Document

A turn-around claim system by itself is not a sufficient control. It prevents errors in billing rates, patient contributions, and charges for additional services, but tends to be self-perpetuating. Good controls must therefore exist over initiating, continuing, and ending billing for recipients.

The State of Kansas has a particularly noteworthy method of initiating nursing home billing. The form used is shown in Figure 4. This form includes not only the Welfare office information, but also the physician's report and recommendations for treatment. Since this is required before a nursing-home can be paid, it ensures that each recipient is admitted by a physician, and that a treatment plan has been prepared.

Form DFA-389 A(7-70)

ADULT CARE HOME SERVICE CLAIM

State Dept. of Social Welfare
State Office Bldg., Topeka, Kans 66612

1. Reference Number	2. Patient Identification Number					3. Patient's Name		4. Level of Care	5. Admission Date			6. Period of Care						7. Check If –		8. Number of Days Billed	9. Daily Payment Rate	10. Total Charged	11. Less Patient's Liability	12. Balance Claimed
												Start			End									
	Prog	Co	Family		Ind.	last	first		Mo	Day	Yr	Mo	Day	Yr	Mo	Day	Yr	Disch	Death					

Provider Name and Address

THE MATERIAL OR SERVICES LISTED HEREON HAVE BEEN DELIVERED OR PERFORMED BY ME AND ARE AVAILABLE WITHOUT DISCRIMINATION AS TO RACE, COLOR OR NATIONAL ORIGIN; THE CHARGE IS CORRECT, JUST AND REMAINS UNPAID IS DUE ACCORDING TO LAW AND IS NOT IN EXCESS OF REGULAR FEES. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS AND ACCEPT, AS PAYMENT IN FULL, THE AMOUNTS PAID IN ACCORDANCE WITH THE FEE STRUCTURES, THAT RECORDS IN SUPPORT OF SUCH CLAIMS ARE SUBJECT TO AUDIT, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

Provider Number

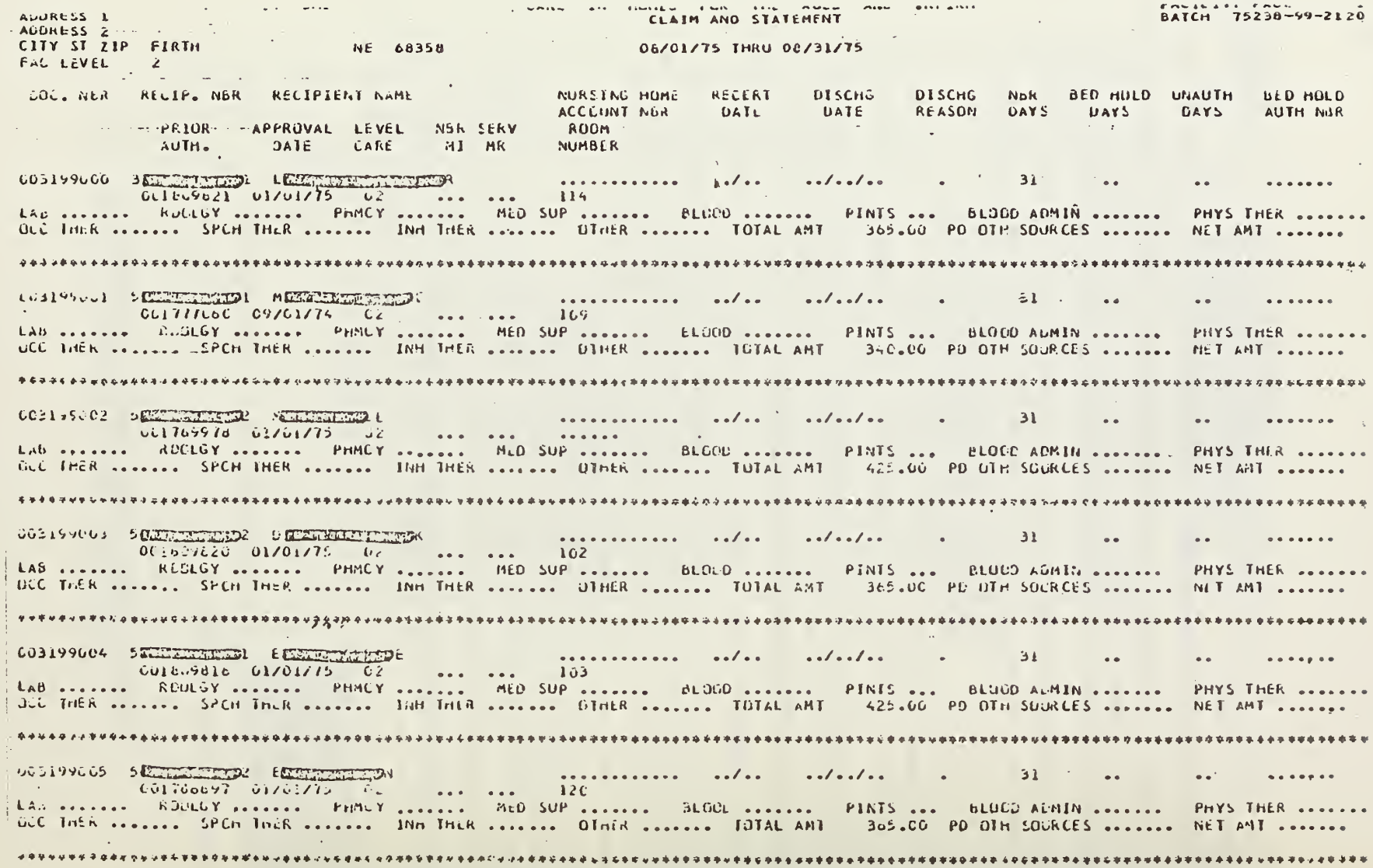
Month of

Page

Signature of Administrator

Date

Figure 2: Example of Turnaround Nursing-Home Claim



ADDRESS 1
ADDRESS 2
CITY ST ZIP FIRTH NE 68358
FAC LEVEL 2

CLAIM AND STATEMENT

BATCH 75238-99-2120

06/01/75 THRU 08/31/75

DOC. NBR	RECIP. NBR	RECIPIENT NAME	NURSING HOME ACCOUNT NBR	RECERT DATE	DISCHG DATE	DISCHG REASON	NBR DAYS	BED HOLD DAYS	UNAUTH DAYS	BED HOLD AUTH NBR
	PRIOR AUTH.	APPROVAL DATE	LEVEL CARE	NSR MI	SERV MR	ROOM NUMBER				
003199000	3	L R	.....	../..	../../..	.	31	..	..	.....
	001869821	01/01/75	02	...	...	114				
LAB	RDLGY	PHMCY	MED SUP	BLOOD	PINTS ...	BLOOD ADMIN	PHYS THER			
OCC THER	SPCH THER	INH THER	OTHER	TOTAL AMT	365.00	PD OTH SOURCES	NET AMT			
003199001	5	L M	.....	../..	../../..	.	31	..	..	.....
	001777106	09/01/74	02	...	...	109				
LAB	RDLGY	PHMCY	MED SUP	BLOOD	PINTS ...	BLOOD ADMIN	PHYS THER			
OCC THER	SPCH THER	INH THER	OTHER	TOTAL AMT	340.00	PD OTH SOURCES	NET AMT			
003199002	5	L	.....	../..	../../..	.	31	..	..	.....
	001769978	01/01/75	02	...	...	.....				
LAB	RDLGY	PHMCY	MED SUP	BLOOD	PINTS ...	BLOOD ADMIN	PHYS THER			
OCC THER	SPCH THER	INH THER	OTHER	TOTAL AMT	425.00	PD OTH SOURCES	NET AMT			
003199003	5	K	.....	../..	../../..	.	31	..	..	.....
	001697220	01/01/75	02	...	...	102				
LAB	RDLGY	PHMCY	MED SUP	BLOOD	PINTS ...	BLOOD ADMIN	PHYS THER			
OCC THER	SPCH THER	INH THER	OTHER	TOTAL AMT	365.00	PD OTH SOURCES	NET AMT			
003199004	5	E	.....	../..	../../..	.	31	..	..	.....
	001869816	01/01/75	02	...	...	103				
LAB	RDLGY	PHMCY	MED SUP	BLOOD	PINTS ...	BLOOD ADMIN	PHYS THER			
OCC THER	SPCH THER	INH THER	OTHER	TOTAL AMT	425.00	PD OTH SOURCES	NET AMT			
003199005	5	E	.....	../..	../../..	.	31	..	..	.....
	001766097	01/01/75	02	...	...	120				
LAB	RDLGY	PHMCY	MED SUP	BLOOD	PINTS ...	BLOOD ADMIN	PHYS THER			
OCC THER	SPCH THER	INH THER	OTHER	TOTAL AMT	305.00	PD OTH SOURCES	NET AMT			

Figure 3: Example of a Turnaround Nursing-Home Claim

KSOME-MFO-FORM 300
KANSAS DEPT. OF HEALTH
ADULT CARE HOME SECTION
535 KANSAS AVENUE
TOPEKA, KANSAS 66601
Care Home Referral Form

FORM OSRS MEO-1
KANSAS DEPT. OF SOCIAL & REHABILITATION SERVICES
MEDICAL SERVICES SECTION
STATE OFFICE BUILDING
TOPEKA, KANSAS 66612
Nursing Home Facility Referral Form

PART A — TO BE COMPLETED BY LOCAL WELFARE OFFICE OR HOSPITAL — PATIENT INFORMATION

1. CO / PROG / FAMILY / C.I. / IND.	2. MEDICARE NO.	3. PATIENT'S NAME: LAST, FIRST	4. SEX M ☐ F ☐	5. BIRTH DATE MO DAY YEAR

6. PROVIDER NO.	7. NAME OF FACILITY TRANSFERRING TO:	8. RESPONSIBLE PARTY: NAME, ADDRESS, PHONE, RELATIONSHIP

9. DATE OF THIS TRANSFER (MONTH / DAY / YEAR)	10. DATES OF STAY AT FACILITY TRANSFERRING FROM: (A) ADM (B) DISCH	11. NAME OF FACILITY TRANSFERRING FROM:

12. DOCTOR IN CHARGE AT TIME OF TRANSFER	13. WILL THIS DR. CARE FOR PATIENT AFTER ADM. TO NEW FACILITY? YES ☐ NO ☐	14. IF NO, NAME OF NEW DOCTOR

PART B — TO BE COMPLETED BY PHYSICIAN — MEDICAL INFORMATION

1. PRE-ADMISSION MEDICAL HISTORY, EXAMINATION, DIAGNOSIS (MAY ATTACH NECESSARY DOCUMENTS) PRIMARY, SECONDARY, INCLUDE DATE OF ANY FRACTURES, HOSPITALIZATION, ETC.	2. DATE OF LAST PHYSICAL EXAM.	3. PROGNOSIS

4. PHYSICIAN'S PLAN OF CARE, RANGE OF SERVICE NEEDS, WRITTEN OBJECTIVES AND ORDERS FOR MEDICATIONS, TREATMENTS, RESTORATIVE AND REHABILITATIVE SERVICES, THERAPIES, DIET, ACTIVITIES AND OTHER SPECIAL PROCEDURES. (MAY ATTACH NECESSARY DOCUMENTS)

5.

SPEECH	NORMAL ☐	IMPAIRED ☐	UNABLE TO SPEAK ☐
HEARING	NORMAL ☐	IMPAIRED ☐	DEAF ☐
SIGHT	NORMAL ☐	IMPAIRED ☐	BLIND ☐
MENTAL STATUS	ALWAYS ALERT ☐	OCCASIONALLY CONFUSED ☐	ALWAYS CONFUSED ☐
FEEDING	INDEPENDENT ☐	HELP WITH FEEDING ☐	CANNOT FEED SELF ☐
DRESSING	INDEPENDENT ☐	HELP WITH DRESSING ☐	CANNOT DRESS SELF ☐
ELIMINATION	INDEPENDENT ☐	HELP TO BATHROOM ☐	BEDPAN OR URINAL ☐ INCONTINENT REQUIRED ☐
BATHING	INDEPENDENT ☐	BATHING WITH HELP ☐	BED BATH WITH HELP ☐ BED BATH ☐
AMBULATORY STATUS	INDEPENDENT ☐	WALKS WITH ASSISTANCE ☐	HELP FROM BED TO CHAIR ☐ BED BOUND ☐

6. IMPORTANT MEDICAL INFORMATION (CHECK IF PRESENT)

ALLERGIES ☐	CONVULSIONS ☐
AMPUTATION ☐	DECUBITUS ☐
COLOSTOMY ☐	PARALYSIS ☐
COMATOSE ☐	(EXPLAIN TYPE)
CONTRACTURES ☐	OTHER ☐

7. T.B. SKIN TEST DATE _____ RESULT _____
CHEST X-RAY DATE _____ RESULT _____
C.B.C. DATE _____ RESULT _____
SEROLOGY DATE _____ RESULT _____
URINALYSIS DATE _____ RESULT _____

8. (CHECK IF PATIENT USES)

CATHETER ☐	HEARING AID ☐
CANE ☐	WALKER ☐
CRUTCHES ☐	WHEELCHAIR ☐
DENTURES ☐	OTHER (EXPLAIN) ☐
EYEGLASSES ☐	

9. TYPE OF CARE PRESCRIBED (REFER TO "GUIDELINES FOR TYPES OF CARE".)

CODES	TYPE OF CARE
1 _____	SKILLED NURSING CARE, 24 HR/DAY-7 DAY/WK PROFESSIONAL R.N. OR L.P.N. NURSING SUPERVISION
2 _____	INTERMEDIATE NURSING CARE, 8 HR/DAY-40 HR/WK PROFESSIONAL R.N. OR L.P.N. NURSING SUPERVISION
3 _____	INTERMEDIATE CARE FOR THE MENTALLY RETARDED
_____	INTERMEDIATE PERSONAL CARE, CARE LESS THAN ABOVE, MAY HAVE SOME PROFESSIONAL NURSING SUPERVISION
_____	BOARDING HOME, MOSTLY SELF-CARE WITH MINIMAL SUPERVISION
_____	1 OR 2 BED HOME

I CERTIFY THAT SERVICES INDICATED ABOVE ARE REQUIRED TO BE GIVEN ON AN INPATIENT BASIS TO THE ABOVE-NAMED PERSON. THE NEED FOR NURSING CARE AS INDICATED ABOVE IS REQUIRED ON A CONTINUOUS BASIS FOR CONDITIONS WHICH HAVE EXISTED REQUIRING PREVIOUS MEDICAL, HOSPITAL AND/OR NURSING HOME CARE PRIOR TO THIS TRANSFER.

DATE _____ SIGNED _____ D.O. or M.D.

Figure 4: Form Used to Initiate Nursing-Home Care

5.8.3 Welfare Office Review of Billing

In order to maintain control over continuing nursing home patients, it is essential that the local Welfare office is informed of the billing, to check level of care, patient liability, and the continued presence of the recipient in the home.

In the State of Nebraska, a special listing is produced by the computer during the month for the Welfare office to enter the patient liability for that month, and to add and delete recipients. One copy is sent to the nursing home and the other to the central office. In this State the home administrator enters the patient liability on the turn-around claim and returns it to the central office, where it is checked by the computer against the Welfare office listing.

Another method of control is to send a copy of the nursing home payment to the local office for confirmation and changes. In this case patient liability is calculated to be the same each month, requiring less work on the part of the social worker.

5.8.4 Periodic Reviews

The state is required to carry out an on-site review periodically. In the State of Oklahoma, a special listing is produced for this purpose, and the social worker is provided with this listing to take with him on this review. He can then confirm that the listing corresponds to the actual situation, including nursing home records of transfers, home and hospital visits, etc.

5.8.5 Duplicate Checks

The nursing home operator is required to correct the turn-around claim if absences occur, or when patients transfer. Occasionally, this procedure is not performed correctly. Such oversights can usually be detected by a cross-provider duplicate check.

The State of Oklahoma runs such a check every six months on its hospital and nursing home histories. This special program detects overlapping service dates and prints out conflicting information. In this way a significant recovery is made from nursing homes for payments made while the recipient was in an acute hospital or transferred to another home. Judging from Oklahoma's initial experience, a much larger number of errors are deterred by the existence of this program.

5.9 Co-ordination of Physician and Hospital Benefits

It is common in many States to reduce the number of days of certain hospital stays, either because of coverage limitations, or because the stay exceeded statistical guidelines without good medical justification. There are good reasons for reducing the physician claim to correspond to the hospital reduction: in some cases, it is actually state policy to do so, and even when not, it is clearly a more effective deterrent to excessive hospital stays, since it is the doctor who places and maintains the patient under care in the hospital.

One method of achieving this is simply to retrieve, from claim history, any related claims when a hospital claim is reduced. (In the State of Kansas, as mentioned earlier, such related claims are in fact retrieved as part of the utilization review process). If related claims have not yet been received, a "tickler" file can be maintained so that such claims are ultimately made available.

A second method of achieving coordination of physician and hospital benefits is in operation in the state of Oklahoma. The state has a coverage limitation of 10 days hospitalization without special review and approval. All hospital stays over 10 days, and all physician treatments in a hospital beyond 10 days are routinely denied unless approval is on file, for a specified additional number of days. It is particularly simple to carry out such a procedure when there is a fixed limit to hospital stays; however, the same technique can be applied whenever doctor's services exceed length-of-stay guidelines based on diagnosis. By requiring approval from the review board to be on file, before payment of doctor's claims over the limit, this policy can be effectively applied.

5.10 Consultant Review

In the State of Connecticut, certain of the medical consultants have instituted the practice of reviewing samples of incoming claims, or all incoming claims for sampled providers. Such a procedure facilitates the detection of improper or erroneous billing patterns which would not be routinely detected during normal claims processing.

5.11 Controls on Cost-Reimbursed Providers

For every type of provider which is cost-reimbursed, the state devises a formula setting out the procedures for determining the amount of reimbursement. Such a formula typically involves three elements: an audit of provider costs, a determination of approved Medicaid charges or utilization, and an equation to pro-rate costs on the basis of approved charges or utilization. For example, hospital accommodation cost reimbursement might be determined by first establishing total accommodation costs via an audit, secondly establishing total approved Medicaid accommodation days, from claims processing statistics, and thirdly computing allowed Medicaid costs by multiplying total costs by the ratio of Medicaid days to total days. Similarly, reimbursement for an ancillary department might be determined by first establishing total ancillary costs via an audit, secondly establishing total approved Medicaid ancillary charges, and thirdly computing allowed Medicaid costs by multiplying total costs by the ratio of Medicaid charges to total charges.

Erroneous payments may result if

a) costs are not computed correctly,

b) approved utilization or charges are not computed correctly, or

c) the claims processing personnel, unfamiliar with the cost-reimbursement formula, do not apply adequate controls for cost providers because they mistakenly believe that such controls are irrelevant in view of the cost audit and settlement.

Of these three causes for erroneous payments, this guide is concerned with the latter two; cost auditing procedures are not considered here. The focus of the following remarks is to insure that the proper data is accumulated

during claims processing and is made available for use in the reimbursement formula:

1. The state should recognize the importance of claims processing controls on cost providers, such as edits for duplicate payments, length of stay, key entry errors, etc., as such controls do affect the ultimate reimbursement. It is typically assumed by cost auditors that tabulations of paid claims reflect only correct and covered charges approved by claims processing. It is not a major function of the cost audit to detect erroneous payments. (On the other hand, certain techniques may be used by cost auditors to provide assistance in such detection; see Section 5.12). Any non-covered, erroneous, or inappropriate charges must be denied during claims processing.
2. At the time of the cost settlement, claims processing tabulations of approved services and charges should be reconciled with the provider's tabulations. The state should not rely on the accuracy of the provider's records. The need for accurate and reliable state tabulations is self-evident. Such tabulations must be organized so that the appropriate categories of data are available for the cost reimbursement formula. Special attention should be directed to the accurate reporting of those data elements (e.g., patient days) used in the reimbursement formula.

3. Claims processing tabulations of approved services and charges should be adjusted for any denied services, or services for which refunds are received.

The reader is referred to Section 2.4 for illustrations of how erroneous payments have occurred because of failure to adhere to these principles.

5.12 Cost Audit Techniques for Detecting Erroneous Payments

The following audits can be of great value in detecting erroneous payments:

1. Medicaid patient accounts may be audited for credit balances. Such a credit balance will usually indicate either a duplicate payment or an unreimbursed insurance payment.
2. Medicaid patient accounts and admission/discharge records may be sampled and compared with actual billing to confirm that the state is correctly billed.
3. Samples may be used to verify that charges to Medicaid patients are the same as those to the general public.
4. Medicaid patient charges may be compared with hospital averages to detect gross differences.
5. Medicaid patient charges and overall hospital averages may be compared with previous year's statistics to detect gross differences.

It is recognized that many states contract with Medicare for common audits. In this case, the above techniques would need to be specified for the Medicare auditors, or alternatively state Medicaid personnel would need to participate in the audit.

5.13 Itemized Hospital Bills

Every state requires hospitals to bill on special claim forms that summarize the information on a recipient's hospital stay. In some cases, the data is so summarized as to be virtually useless; e.g., "out-patient services, $256", or "room charges, 5 days, $300", "Ancillary Services, $250". States that require no more than this have little choice but to pay as billed, with the hope that any abuses or errors will be resolved in the annual cost audit. Unfortunately, the cost audit is ill-equipped for performing comprehensive checks for erroneous payments. The audit must rely on accurate data from claims processing, data which is based on accumulations of approved correct charges.

Hospital claims may best be controlled by requiring:

1. A claim with a detailed breakdown of room charges according to categories as used in the cost audit, e.g., semi-private bed, nursery bed, intensive care.
2. A departmental breakdown of ancillary charges.
3. A copy of the itemized billing, giving details of all services and supplies, including date of service.

Most hospitals have complete accounting systems which produce itemized bills for their private patients. (The Medicaid claim is normally summarized from such a bill.) This itemized billing is important any may be used for several purposes:

1. Checking accuracy of summary.
2. Appropriately reducing ancillary charges when length-of-stay is reduced.
3. Ensuring that non-payable charges are eliminated, such as luxury items (T.V., telephone, etc.) or charges by hospital-salaried physicians that bill separately.

4. Partial confirmation that charges to Medicaid are no different from charges to the general public.
5. Checking for duplicate billings, particularly of outpatient services.

The last point needs further discussion. A possibility of error arises when a patient seen in the outpatient department or emergency room is admitted to the hospital on the same day, and the hospital is permitted (or even required) to bill on separate forms. It is very possible for ancillary services, such as x-rays, lab-tests, etc., to be billed with the outpatient service, and then rebilled on the inpatient claim, hidden away in the global sum for ancillary charges. The only way to detect this is by a careful examination of itemized charges. One method for avoiding this problem is to require that outpatient charges are billed on the inpatient bill when the patient is admitted on the same day.

5.14 Edit Bypass and Override Procedures

Erroneous payments may be made as the result of bypasses or overrides which circumvent normal claims processing edits. Problems which have been observed in some states include:

a) A state may bypass edits as a means of reducing processing backlogs.

b) Some systems, when a claim is suspended for manual review, do not list all reasons for the suspension. As a result, the claim may be approved with a force code entered which overrides edits for potential errors not apparent to the claim reviewer. This problem is diminished if all exception reasons are listed at once or if override codes are very specific to particular edits.

c) Some systems, when performing edits related to recipient history (e.g., duplicate edits) do not consider suspended claims as part of history. Consequently when a suspended claim is approved, it will not have been exposed to all claims processed in the time between suspension and approval. Consequently, if a force code is used, erroneous payments, e.g., duplicate payments, may result. This problem also is diminished if override codes are very specific to particular edits.

d) In some states, override codes are used at the same time that claim data is corrected by claims processing personnel. Thus, the corrected data may not be subjected to normal editing procedures.

In light of these possible problems, the following suggested practices can help reduce erroneous payments:

1. Whenever edit bypasses are used (i.e., edit turned off for all claims), control procedures should be instituted to insure that bypasses are not in critical control areas and that they are not implemented by unauthorized personnel.
2. When a claim is corrected after failing an edit, it should then be subjected again to all other edits. If the failed edit is overridden, the override code should preferably be very specific to the particular edit.
3. When a claim fails an edit, all reasons for all possible errors should be printed out. Note, in systems which may either suspend or deny claims in error, it is especially important that the reviewer be aware of any "denial" reason that was overridden by a "suspend" reason.
4. When a claim is suspended for manual review there should be a computer printout of the claim information. In this way, the reviewer can ascertain that the original invoice information agrees with the information entered and stored in the computer. Without such a match of information, the reviewer could unknowingly approve a claim entered erroneously.
5. During the processing of history edits, a claim should be edited against all claims preceding it in processing, including claims not yet resolved (i.e., not yet approved or denied)and hopefully including denied claims. It is important to edit against claims not yet resolved so that when the latter are approved they will have been exposed to claims processed since their time of suspension. It is important to edit against denied claims so that claims which were difficult to resolve will not require duplicate effort when identical claims are

re-submitted. Also, such editing avoids the possibility of overlooking a denial reason which was established for the original claim.

5.15 Information Feedback

In many instances, information is available in one area of Medicaid operations which would be valuable to some other functional group, but no established lines of communication for that information exist. Listed below are instances where such feedback is desirable:

1. When a claim indicates that a patient has died (e.g., through discharge reason), that information should be used to update the eligibility records and forwarded to the welfare office.
2. When an attorney requests a listing of Medicaid expenses for his client (either from a provider or from the Medicaid office), that information should be referred to the third party liability recovery unit.
3. When a third party or medical insurance recovery is made on one claim, related claims should also be investigated, as a routine procedure.
4. If an insurance payment appears on a claim or a refund is received from a provider after collection from other insurance, and if other insurance is not indicated on the eligibility file, this data should be captured and flagged for further investigation.
5. When it is observed that a particular provider has an improper billing practice for one or more procedures, that provider can be placed on review so that all claims with those procedures are suspended. Past claims of the provider should be investigated for possible additional recovery.

6. If one service is disallowed, related services can be investigated for the same episode of care by the same or different provider. For example, if a hospital stay is disallowed, it may be desirable to disallow related hospital visits and ancillary charges.

7. If Medicare reduces, disallows, or corrects an error on a previously paid claim, this information is of use for consideration of the Medicaid portion of the same claim.

8. If a claim is reduced or denied, the provider should be made aware of the reason, either via the remittance document or an information copy of the adjusted invoice. Such notification prevents duplicate billings and promotes provider education.

APPENDIX

POTENTIAL ERRONEOUS PAYMENT SITUATIONS

A.1 INTRODUCTION

This appendix provides a basic list of potential erroneous payment situations which are generally applicable to all states. These situations may be considered as a "test matrix" which can be used to determine the adequacy of state controls. That is, if the state had a facility for testing system response to fictitious claims, the list of claim situations in this appendix could be used to generate a comprehensive set of test claims which are known to be erroneous and which thus provide a good test of the state's controls. While most states do not have such a facility for test claims, such a list of erroneous situations can nevertheless be used as a guide to determine the presence or absence of controls for detecting each such situation. That is, one can ask, "what would occur if such a claim were submitted?" The list of erroneous claim situations has been developed for the purpose of such an approach.

The list in this appendix should be custom-tailored to the specific policy and regulations of the state. In some cases, the list indicates that particular erroneous claim situations are conditional on state regulations, and in these cases, the State Plan and provider instructions must be examined to determine whether the claim situation must be changed to fit the particular state situation. Additionally, the State Plan and provider instructions must be examined to determine whether additional claim situations should be added to reflect specific state policy or regulations. For example, if the provider instructions state that "chiropractic visits over two per month must be prior authorized", then an appropriate erroneous claim situation is "Claim for third or greater chiropractic visit in a month, without prior authorization".

The state must determine, for each claim situation specified in this

ix and for any additional situations identified as applicable to state, the controls utilized in the state's claims processing system prevent an erroneous payment. For each claim situation listed, the results of the investigation should be noted on the worksheet shown: disposition of claim by the normal operating procedures (e.g. claim denied, returned to provider, payment reduced, etc.), method of detection of the situation (e.g. manual vs. computer identification), potential and actual use of edit overrides (e.g., is this edit active at all times, for all providers, etc.), and any other comments which are applicable. The information summarized on these worksheets will provide the basis for a qualitative evaluation of the edits and audits employed by the claims processing operation.

It must be remembered that it may not be cost effective to fully control all of those situations where control gaps are noted. What is most important is that a formal decision be made by the state on the cost-effectiveness of controlling each situation. (See Section 4 for more discussion of this point.) Nevertheless, at this stage, the analyst using this list should not attempt to make a judgment on cost-effectiveness but rather should indicate on the worksheet only the presence or absence of controls.

Note that for many erroneous claim situations in this appendix, annotations are given in the right-hand margin. These annotations are designed to aid the analyst in understanding the claim situation and in ascertaining the appropriate answers.

Information on the capabilities of normal edits and audits to detect the various erroneous claim situations should be obtained from persons familiar with the operating system and on reviews of the system documentation. The analyst should become sufficiently familiar with the system to answer specifically how each situation is controlled. For each erroneous payment category, types of

erroneous claims which could possibly be paid without detection should be noted. Note, the analyst must understand that the questions are aimed not at determining what policies the state has adopted, but rather what controls are actually in operation to enforce those policies. For example, a state may have a policy to disallow certain types of claims but no control which serves to detect those claims.

A.2 POTENTIAL ERRONEOUS PAYMENT SITUATIONS

	Potential Erroneous Payment Situation	Explanatory Notes
A.2.1	Ineligible Recipient	
(1)	recipient not on eligibility file	
(2)	recipient not on file on service date, retroactive eligibility covers service date	Claim should be paid.
(3)	recipient on file, not eligible at any time during service period	
(4)	recipient on file, eligible for only a part of service period	
(5)	recipient on file, date of service is after previously received claim reported death	Is information on recipient death used to update eligibility file? Is it forwarded to welfare office?
(6)	recipient ID number is valid, but name on claim does not correspond to name on file	Are there edits to check recipient number against first and last name? Important for verifying eligibility as well as performing history edits such as for duplicates.
(7)	recipient has valid card, but eligibility has been cancelled	Only of concern if state issues cards less frequently than once a month.
A.2.2	Ineligible Provider	
(1)	provider not on file	
(2)	provider on file, not enrolled during any of service period	
(3)	provider on file, enrolled for only part of service period	

(4) provider on file, but not certified for type of service billed	
(5) provider number on file, but name does not correspond	Are there edits to check provider number against provider name? If not, are pre-printed claim forms distributed to providers containing name and identification number?
A.2.3 Duplicate Payment	
A.2.3.1 Exact Duplicate Claims	
(1) same date, provider, recipient, service type, charge, procedure and/or diagnosis (for dental--same tooth) as previously paid claim	
(a) 2nd claim received in a different edit processing or check-writing cycle	
(b) 2nd claim received in same edit processing or check-writing cycle	
(c) 2nd claim received on same invoice	
(2) same as (1), previous claim suspended	The significance of this situation depends on the types of override codes used to force through a pended claim.
(3) same as (1), previous claim denied	Of particular concern when previous claim went through a considerable review prior to denial.
A.2.3.2 Near Duplicate Claims	
The following situations are intended to refer specifically to cases where an actual duplicate billing has occured. However, these situations overlap considerably with situations that are not actual duplicates, but may be some other type of erroneous payment situation. For example, 7(b) could be a real duplicate bill for the same service billed under an individual number, or it could be a case of concurrent care by two physicians.	

In essence, these situations are detected by a "combination edit", in which certain combinations of procedures, provider, service dates, etc. are considered suspect. Refer particularly to Section A.2.7.1 later.

(1) same as exact duplicate except a different but comparable procedure is listed (e.g., different types of office visits, different variations of the same surgical procedure, or misinterpretation of a description in a procedure code manual resulting in a billing for both a basic procedure and a listed variation)

(2) same as exact duplicate except dates of service are overlapping or different but in close proximity

Dates in close proximity would be of interest, for example, for expensive surgical procedures.

(3) same as exact duplicate except different provider

(4) same as exact duplicate except different charge

(5) same as exact duplicate except different provider service type, e.g.,

- (a) claim for services by salaried staff of provider (for example, physician on salary included in inpatient hospital costs, bills separately under his own provider number)
- (b) physician bills for services administered in clinic, group practice, or outpatient facility when latter also bills
- (c) pharmacy charges separate from inpatient, SNF, or outpatient facility
- (d) physician bills for analyzing lab (or x-ray) results which are included in laboratory (radiology) charges

(6) same as exact duplicate except different recipient number

Are there controls to insure that there are no duplicate eligibility records for the same date, e.g., due to change in county or aid category? Are there controls to insure that claims are paid under the correct eligibility number so that duplicates will be detected? Problems can occur when eligibility overrides are used.

(7) various combinations of the above, e.g.,	
(a) two practitioner claims for a similar major surgical procedure within a short period of time (possibly from different providers)	
(b) two practitioner claims for visits (possibly different types) on the same day (possibly from different providers)	
(c) two claims with different charges for overlapping dates of service	
(8) a fee-for-service claim for a recipient enrolled in a pre-paid health plan which provides the given type of service	Applicable only if the state contracts with PHP's.
A.2.4 Above Allowed Reasonable Charges	
(1) claim amount exceeds maximum limits on fee file	Medicaid should not pay more than maximum limit. Are there any claim types for which there are no fee files?
(2) amount claimed does not exceed limits on file but these limits are higher than in source documents or by intended method of calculation	What procedures are there to insure accurate data on fee file? Is the file sampled for accuracy?
(3) claim amount exceeds Medicare payment for the same service by the same provider	Federal regulations prohibit paying more than Medicare limit.
(4) Title XVIII claim for deductible and co-insurance where original amount billed under Medicare exceeds allowable Medicare amount	Medicaid should pay Medicare allowed amount less Medicare payment, NOT billed amount less Medicare payment.
(5) claim amount is less than fee amount allowed by schedule	In this case Medicaid should pay claimed amount.
(6) adjustment (supplemental payment) to original claim results in combined charge exceeding limits on fee file	Adjustments are often handled differently from original claims, and may not be subjected to all of the usual edits.

(7)	claim for procedure after a rate change	Claim for service rendered prior to new rate should receive old rate. Does fee file have provision for different rates on different service dates?
(8)	duplicate claim which shows lower amount billed than original claim paid	Medicaid should pay lower amount, request refund of original.
(9)	claim amount exceeds limit on fee file and there is a partial or total payment by recipient or other insurance	Other payment should be deducted from reasonable charge, not billed amount.
(10)	amount approved on prior authorization exceeds amount in fee schedule	Are payment amounts authorized? If so, are they edited against the fee file?
(11)	pharmacy claimed wholesale cost exceeds actual cost	Is there a fee schedule for drugs? If not, are there spot audits of pharmacies?
(12)	pharmacy claim exceeds price paid by public for same item	Can arise where "mark-up" is less than dispensing fee. Are there spot audits of pharmacies?
(13)	incorrect room rate for institutional claims	Is there a file of accomodation rates which is checked during processing?

A.2.5 Other Sources of Payment Available

Federal regulations require that all other sources of funds be exhausted before Medicaid benefits may be applied. There should therefore be some method or methods of detecting the possibility of other sources, such as other medical insurance, accident liability, etc., as well as methods for following up on these possibilities or ensuring that the provider has done so.

A.2.5.1 Accident Liability

(1)	an accident related procedure or diagnosis is listed but no third party liability information is received	Is claim referred for follow-up?
(2)	provider indicates accident on claim form but there is no payment by third party or payment by third party is incorrect amount	Are accident cases referred for follow-up?
(3)	Service resulted from an accident but there is no indication on the claim	Does the claim form specifically ask if care is related to an accident?

A.2.5.2 Other Insurance		
(1)	no indication of other insurance on claim; eligibility file shows other medical resources	Is insurance data maintained on the recipient file? How specific is information on other insurance? Is this information printed on the recipient's identification card? Can edits distinguish types of care where there is no coverage? Are claims referred for follow-up if recipient has coverage?
(2)	other insurance pays incorrect amount or incorrectly states there is no coverage or provider states there is no coverage	Is detailed policy coverage data maintained for most common policies? Does state require copy of insurance correspondence or remittance? Does state periodically audit insurance payments? Note, provider might incorrectly state there is no coverage because the recipient must satisfy a deductible. In this case, it is important that Medicaid payments be credited towards the deductible.
(3)	some indication of other insurance on invoice (box checked or credit taken) and eligibility file shows no insurance	Is there a clear yes/no question on the claim form relating to other insurance? Is the data used to update the eligibility file? Are other similar claims audited for possible application of this insurance?
(4)	claim were eligibility file or claim indicates other insurance and the amount paid by the insurance company is unreasonably small	Is there a reasonableness edit? Is detailed policy data maintained?
(5)	other insurance billed but not yet paid, claim paid by Medicaid; no insurance payment received after significant time has elapsed	Does state follow-up to conclude that other insurance should not pay, or if it should, to make collection?
(6)	other insurance billed not but yet paid; provider has not allowed sufficient time to pass before billing Medicaid	For states which permit providers to bill Medicaid when payment has not been received from other insurance within a specified time.

A.2.5.3 Medicare	
(1) recipient eligible for Medicare (A and/or B) and Medicare has not been billed	Is Medicare coverage indicated on recipient file?
(2) claim for recipient over 65, no indication of Medicare coverage	If no claim edit, is there a frequent, i.e., monthly, processing of eligibility files to extract such individuals?
(3) Medicare co-insurance/deductible for payments not ordinarily allowed by Medicaid (e.g., for reasons of coverage or service limitation)	Will Medicaid pay co-insurance and deductible?
The following three situations usually apply only when provider submits bill, rather than having it directly transmitted from Medicare carrier.	
(4) Medicaid's portion of Medicare co-insurance/deductible incorrectly listed	Is there sufficient information on claim to check correctness of amount? Is Medicare EOMB required?
(5) cumulative Medicare deductible for Part B services exceed $60.00	
(6) Medicare co-insurance/deductible for service disallowed by Medicare (e.g., for overutilization)	Not really a problem of other insurance, but included here for discussion convenience.
A.2.5.4 Patient Liability	
(1) claim amount includes the last portion of patient's spenddown requirements	Is claim prorated? If so, how?
(2) date of service is prior to date on which spenddown requirement was met	
(a) claim was used as part of spenddown requirement	Claim should not be paid.
(b) claim was NOT used as part of spenddown requirement	What procedures are used to handle these claims which ARE payable?

(3) incorrect patient contribution (including social security) is deducted on a SNF or ICF claim for a full time resident	Incorrect deduction includes the case where deduction is taken when it shouldn't be. Are claims edited against a file containing data on required patient contribution?
(4) claim for services provided prior to death of a medically needy recipient when recipient leaves an estate capable of payment	
A.2.5.5 Co-Payment	
(1) provider increases fee to compensate for co-payment	Only applies in a state that requires a co-payment from a recipient.
(2) provider fails to deduct co-payment	Does system deduct co-payment automatically?
A.2.6 Incorrect and/or Incomplete Claims	
(1) incomplete claims, including invalid (not computer-acceptable) codes submitted or keyed, e.g.,	
(a) ID number missing	
(b) charge not given	
(c) initials or signatures of preparer missing	
(d) invalid, missing, or out of range data	
(e) additional information or documentation needed	
(2) unreasonable entries submitted or keyed, e.g.,	
(a) unreasonable charges, such as	
(i) charge differs from fee file by significant amount	Are there "variance" edits to detect such situations?
(ii) no fee on file, but charges seem ridiculous (e.g., ancillary charges)	Are there reasonableness limits for such charges?
(iii) implied late discharge fee is unreasonable	Can a hospital bill a late discharge fee by submitting charges greater than days x per diem?

(b) unreasonable time sequence, such as	
(i) end service date not sequential to start	
(ii) date of discharge not sequential to date of admission	
(iii) claim process date not sequential to end service date	
(iv) date of discharge not within service period	
(c) unreasonable quantities, such as	
(i) ridiculous number of services, days or visits	Are there reasonableness limits?
(ii) service period less than number of visits/accomodation days	
(iii) incorrect dispensing unit of measure on pharmacy claim (e.g., ounces rather than tablets)	Are there variance edits on amount charged versus amount allowed for the specified number of units?
(iv) subtotals don't balance as submitted or keyed	
(v) charge per service or day multiplied by number of services or days does not equal total charges	
(3) incorrect procedure submitted or keyed and procedure code not on file	
(4) incorrect drug code which is (by chance) a valid drug code on file	Can be controlled through use of a check digit.
(5) incorrect ID number of provider or recipient submitted or keyed and ID number is (by chance) valid	In this case ID number would not correspond to name. See under eligibility in Section A.2.1 (6) and A.2.2 (5).
(6) procedure incompatible with:	
(a) diagnosis (e.g., appendectomy for tonsillitis)	
(b) age (e.g., obstetrical delivery for 5-year-old)	

(c) sex (e.g., obstetrical delivery for a male)	
(d) specialty (e.g., open heart surgery by a gynecologist)	
(e) provider type (e.g., heart surgery by a dentist)	Can the system detect if a dentist bills on a physician form?
(f) past procedure (e.g., maternity care after hysterectomy, extraction of same tooth as previously, etc.)	
(g) written procedure description	Do qualified personnel check procedure code against the description?
(h) place of service (e.g., heart surgery in the office)	
(7) miscellaneous key entry errors	Is there verification? Check digits? Quality assurance? Or are there sufficient cross checks and logical checks as above?
(8) claim inconsistent with supporting documentation (e.g., inconsistent with Medicare EOMB, or procedure inconsistent with operative report, or ancillary charges inconsistent with itemized billing)	
A.2.7 Other Payments Not Allowed by Regulation or Policy	
A.2.7.1 General	
(1) non-covered service which has a prior authorization	Will edits for non-covered services be overriden?
(2) disagreement between claim and prior authorization	
(a) recipient ID does not match	
(b) provider ID does not match	
(c) procedure code does not match	
(d) diagnosis code does not match	

	(e) dates of service do not match authorization dates or authorization has expired	
	(f) claim amount exceeds authorized amount	
	(g) no prior authorization obtained for service requiring such	
(3)	service not billed within billing time limitation	(Note: limitation cannot exceed Federal limit of 24 months)
(4)	claim for service which is rendered free to general public (e.g., testing for venereal disease)	If these procedures are not allowed, can they be distinguished (e.g., through separate codes) from allowed procedures such as office visits?
(5)	claim for broken appointments	Prohibited by Federal regulations. If billed, can these be distinguished from allowed procedures? Is there a separate code for broken appointments?
(6)	claim for services which are allowed for one but not both of the medically needy and categorically needy groups	Depends on policy in State under review.
(7)	claim for sterilization of recipient	Prohibited by Federal regulations.
	(a) under 21 years of age	
	(b) legally incapable of consent	
	(c) without written consent	
	(d) performed within 72 hours following consent	
(8)	miscellaneous non-covered services	If billed, can these services be distinguished from allowed services which may be related? One method is to establish separate procedure codes for non-covered services and to deny claims with these codes. Such codes eliminate ambiguity.

A.2.7.2 Physician

(1) procedure claimed is inappropriate (e.g., a more expensive procedure or more extensive visit than appropriate)	Can certain procedures be made to suspend automatically? Are there post-payment edits on certain potentially-abused procedures? Is procedure code matched with description? Are there limitation edits which detect initial office visits? Are there requirements for supporting documentation when extensive procedures are billed?
(2) claim for an item not listed in fee schedule	Some states may allow payment upon suitable justification such as a report.
(3) procedure code requires report and one is not submitted	
(4) physician claims for hospital visit during portion of a hospital stay which was previously disallowed or reduced (e.g., for exceeding length-of-stay restrictions)	Are hospital visits also disallowed?
(5) assistant or co-surgeon bills for a surgical procedure which does not warrant more than one surgeon	Does procedure code file indicate if more than one surgeon allowed?
(6) assistant surgeon bills without indicating assistant status (e.g., through use of procedure modifier code or type of service code)	Is claim detected as a near duplicate of primary surgeon's claim?
(7) assistant surgeon bills correct percentage of his customary full surgical fee, does not indicate assistant status, and his full fee is higher than full maximum allowable	Is claim detected as a near duplicate of primary surgeon's claim?
Items (8) through (15) are all of the general type in which more than one service is involved in a combination that could imply an erroneous payment.	
(8) procedures incidental to major surgery (e.g., biopsy, endoscopy, more than one procedure in an incision) performed by	
(a) same physician	

(b) other physician	
(9) one procedure incidental to and included in another (e.g., insertion of IUD in conjunction with abortion; blood pressure reading in conjunction with an office visit; pelvic examination in conjunction with an office visit)	
(10) multiple surgery (secondary surgery should be paid at lesser amount)	
(11) pre or post-operative care associated with major surgery or maternity performed by	Pre and post-care is defined specifically by state policy. Is there a distinction between pre and post-care in the hospital and pre and post-care in the office?
(a) same physician	
(b) other physician	
(c) other provider type (e.g., hospital outpatient department)	
(12) several single procedures which should be paid at rate of one inclusive procedure (e.g., laboratory panels)	Sum of parts would be more expensive than the single inclusive procedure.
(13) consultation after physician has "assumed care"	Are excessive consultations within private clinic or group practice also controlled?
(14) second consultation within specified time period	
(15) second initial office visit within specified time period	
Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.	

(16)	follow-up hospital visit billed on same day as minor surgery by	
	(a) same physician	
	(b) other physician	
	(c) other provider type	
(17)	more than one physician billing for regular and continuing patient care	
(18)	medical procedures including surgery considered experimental or not generally employed by medical profession	
(19)	cosmetic surgery	
(20)	elective surgery	
(21)	claim violating frequency limitations on visits or other services	
(22)	claim received where provider fails to use procedure modifier code or type of service code to indicate special billing situation (e.g., multiple surgery, co-surgeon, surgery follow-up care only, "professional component" only, etc.)	For example, what procedures are there to detect a co-surgeon who fails to indicate his co-surgeon status through use of a modifier code?
(23)	claim received where provider has made improper use of a procedure modifier code or type of service code which could result in overpayment	Are claims with modifiers which result in extra payment suspended for review?
(24)	house calls	
(25)	routine physical or immunization	If these procedures are not allowed, can they be distinguished (e.g., through separate codes) from allowed procedures such as office visits?
(26)	claim where anesthesiologist includes base units	Only applies in states in which time units are billed and system automatically adds base units.

(27) referring physician not indicated	Only applies when required by state regulations.
(28) claim for services provided as anesthesiologist without name and license of primary operating physician	Only applies when required by state regulations.
(29) assistant surgeon bills without naming primary surgeon	Only applies when required by state regulations.
A.2.7.3 Inpatient	
(1) private room without certification	Either on claim or in hospital records. If the latter, does an audit confirm?
(2) whole blood when	
(a) other sources available, or	
(b) replaced	
(3) inpatient charge where admission not certified by physician as medically necessary	Does a field audit confirm certification of admission?
(4) luxury items or other non-covered charges	Are such items detected if included in a "catch-all" ancillary category (e.g., "other")?
(5) personal care	
(6) inpatient stay exceeds length-of-stay guidelines	Depends on specific state policy. If a stay is reduced, are ancillary charges also reduced?
(7) significant inpatient stay for minor illness	Most applicable for states which have uniform or no length-of-stay requirement.
(8) hospital admission for diagnostic purposes which could be carried out in a doctor's office or on an outpatient basis	For example, as indicated by little or no drug charges.

(9) readmission (any hospital) within specified time after discharge, to circumvent length of stay guidelines	
(a) same or similar diagnosis	
(b) different diagnosis	
(10) split billing of hospital stay (stay is divided into two or more parts for billing purposes) where total stay exceeds length of stay guidelines	
(a) admission date correctly given on each split claim	Does length-of-stay edit compute number of days based on admission date?
(b) admission date on second claim is incorrectly given as "from" date of service	Is there a history edit to detect an earlier date?
(11) claim for institutionalized patient on day of admission as well as day of discharge	Are number of days checked against admission and discharge date?
(12) excess time between date of surgery and hospital admission date	
(13) surgery set-up charges on inpatient claim when surgery cancelled (e.g., billed under operating room ancillary charges)	
(14) specific diagnoses for which hospital stay not justified	
(15) short-term psychiatric or TB services	
A.2.7.4 Long Term Care	
(1) claim for SNF or ICF where patient admission not certified	How is payment information reconciled with field reviews?

(2) SNF or ICF charge after patient certification discontinued	Are there procedures for providing the claims processing system with information on which patients have been recertified and for what level of care? Are there audits to check for such recertifications? Are there procedures to ensure that the results of medical and professional review are implemented (retroactively if appropriate) in the claims payment system?
(a) end of certification by non-recertification	
(b) end of certification or change in level of care determined by state medical or professional review	
(3) private room without certification	
(4) level of care billed for a particular patient does not agree with level of care currently authorized	
(5) claim for luxury items (radio, T.V., elaborate personal care)	
(6) a claim for a recipient who is out of the nursing home for:	
(a) therapeutic home visit	Federal regulations allow 18 home visit days in a 12 month period. Are there controls to determine if these days are exceeded? If no claims processing controls, are there on-site audits for patient absences?
(b) transfer to another home	
(c) acute hospitalization	Federal regulations allow 15 "bed-hold" days for a single hospital stay.

(d) discharged or deceased	Are patient records reconciled with claims payments?
(7) claim for recipient not receiving an in-facility review	Are there procedures (e.g., through a turnaround document) for providing the claims processing system with information on which recipients have been reviewed? Alternatively, do the review teams have access to payment records indicating for which patients there have been claims submitted.
(8) drug charges in SNF or ICF	Depends on state regulations. If such facilities can bill drug charges, the same controls as for pharmacy claims should apply. See CFR 250.30 (b)(2)(iv).
(9) SNF or ICF services not customarily provided for in these facilities	
(10) a claim for a long-term care recipient who receives an inordinate amount of ancillary services or services not consistent with diagnosis	

A.2.7.5 Pharmacy

Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.

(1) specifically non-covered legend drugs	
(2) charge for maintenance drugs in less than minimum quantity	
(3) repeat prescription or refill where original was for a quantity less than a minimum supply	
(4) over-the-counter (OTC) drugs	
(5) drug refill too early for previous quantity to be consumed	

A.2.7.6 Dental

Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.

(1) any of the following services more than once within a specified time period:	Limitations specified by individual state regulations.
(a) initial exam	
(b) periodic oral exam	
(c) prophylaxis	
(d) topical fluoride application	
(e) diagnostic x-rays	
(f) full series x-rays	
(g) restorative work on same tooth surface	
(h) patient education	
(i) other services with limitations over time	
(2) dental laboratory services (dentist pays)	
(3) administration of analgesia, local anesthesia, or regional block anesthesia in conjunction with operative or surgical procedures	When surgical fee is intended to include anesthesia.
(4) hospitalization for dental work	

A.2.7.7 EPSDT

(1) screening services for recipient over 21	
(2) screening service by a provider not certified specifically for screening	

(3) screening service without referral made for abnormality found	
(4) screening service with fewer than the required number of examinations	
Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.	
(5) second screening service claim within specified time	
(6) screening services not requested by local health office	

A.2.7.8 Optical

Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.	
(1) more than one routine eye examination and/or change of glasses in a specified time period	
(2) eye exercises (orthoptics)	
(3) charge for lens greater than lab cost to provider	Is copy of invoice required for verification?
(4) multiple pairs of glasses for the same individual	
(5) lens replacement filled when refraction correction is less than some specified amount	Actual change in correction must be determined from state regulations.
(6) purchase or repair of wire frames	
(7) contact lenses	
(8) tinted lenses	
(9) sunglasses	

A.2.7.9 Other Services

(1)	tuberculosis facility for recipient less than 65	
(2)	mental facility for recipient less than 65	
(3)	long-term TB or psychiatric patient in institution other than TB or certified mental institution	
(4)	independent laboratory services not ordered by physician	Does claim require name and license number of referring physician?
(5)	home health services not properly certified for patient	
Some or all of the following situations may be relevant to an individual state, depending on the regulations or policy of that state.		
(6)	emergency transportation without documentation	
(7)	home health agency services provided to a patient in a hospital, SNF, ICF, or government institution	
(8)	home health aide claim submitted by member of recipient's immediate household	What controls are exercised on enrollment of such providers?
(9)	domestic or housekeeping services	How can such services be distinguished from home health services?
(10)	day care services	How can such services be distinguished from home health services? from hospital outpatient care?
(11)	"meals on wheels"	How can such services be distinguished from home health services?
(12)	custodial care	How can such services be distinguished from home health services?

(13) psychological testing for educational diagnosis, school or institutional placement, or on court order

(14) physical or speech therapy claim without proof of medical referral by physician

(15) speech, physical or occupational therapy outside of institution

(16) remedial education

(17) services of Christian Science nurses or spiritual healers

(18) private duty nurse or attendant

(19) chiropractor services

(20) audiologist services

(21) psychologist or social worker services

(22) routine foot care

(23) family planning services or supplies

(24) medical equipment and supplies

(25) prosthetic devices

(27) false teeth, wigs, artificial breasts, hearing aids

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